Health Care Financing Grants and Contracts Report

National Hospital Rate-Setting Study, Vol. VIII

Case Study of Prospective Reimbursement in Washington

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Case Study of Prospective Reimbursement in Washington

This report was made pursuant to contract No. 500-78-0036 between Health Care Financing Administration and Abt Associates Incorporated, Cambridge, Massachusetts.

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Published by HEW
Health Care Financing Administration
Office of Research, Demonstrations,
and Statistics
April 1980

WASHINGTON

The Washington State Hospital Commission (WSHC) was created as an independent commission by legislation passed in 1973. Prospective reimbursement was not actually implemented until 1975. The Commission is composed of five members and is supported by a full-time staff, with responsibility for budget analysis and preparation of recommendations to Commission members. Hospitals that are dissatisfied with their approved budgets may request an informal hearing with the Commission, request a mid-year amendment or petition for a formal hearing before a state hearing officer.

The analytic procedures used in Washington rely heavily on inter-hospital cost comparisons. Trends in cost, utilization, service mix, available beds and other general statistics are evaluated. Peer-group comparisons are used to identify cost categories in which base-year and projected rate-year spending are inconsistent with patterns in similar hospitals. The WSHC program does not allow hospitals to opt out of the detailed review process by accepting a global cap on expenditure increases from one year to the next. WSHC is experimenting with alternative prospectively determined payment mechanisms for different hospitals--one based on flat payments of each payor's projected portion of approved total revenue and another based on a percentage of charges.

The findings of WSHC are enforced by means of a year-end settlement. Excesses or shortages in revenue are accounted for by adjustments in approved revenue for the following year. If hospitals set charges that are inconsistent with approved revenue levels, the hospital may be legally prosecuted. To date, the year-end settlement has been the only enforcement mechanism the Commission has found necessary.

ACKNOWLEDGMENTS

The authors would like to acknowledge that information for this case study was provided through personal and telephone interviews, correspondence and secondary data supplied by many people. A list of these people is included in Appendix D of this report.

The authors would like to especially acknowledge the following people for the generous amount of time and effort they contributed to our knowledge.

Mr. Frank Baker
Director
Washington State Hospital Commission

Mr. John Bigelow
President
Washington State Hospital Association

Mr. Jon Bowman
Commissioner
Washington State Hospital Commission

Mr. Joe Davis
President
Washington State Labor Council

Dr. Ludwig Lobe
Chairman
Washington State Hospital Commission

Dr. Arch Logan Jr.
Commissioner
Washington State Hospital Commission

Mr. John Robinson
Director, Fiscal Affairs
Washington State Hospital Association

Sister Charlotte Van Dyke
Commissioner
Washington State Hospital Commission

Mr. Kenneth Webster
Commissioner
Washington State Hospital Commission

In addition, the authors would like to thank Mary Schumacher, and earlier Kim Lanzillotti, for their editing assistance in this final product. Extensive thanks go to Sharon Snyder for coordination of the site visits, copy editing, management of production and most importantly, formatting of text and tables. Last, but certainly not least, thanks go to Valerie Simpkins, who assisted in the typing and production of this report.

Also, the authors express sincere appreciation to HCFA staff for their technical assistance, especially to prior project officers, Fred Hellinger, Ruth Lis, Arne Anderson, and Bruce Steinhardt.

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FOREWORD

The following case study report of prospective reimbursement in Washington has been written as part of the National Hospital Rate-Setting Study. This study is being conducted for the Office of Research, Demonstrations, and Statistics of the Health Care Financing Administration, U.S. Department of Health, Education, and Welfare, by Abt Associates Inc., Policy Analysis, Inc., and Health Economics Research, Inc.* The overall goal of the three-year study is to determine the impact of rate setting on hospital costs, quality of hospital care, and access to health care by the elderly and the economically disadvantaged. In addition, the study will examine the impact of prospective reimbursement on other areas of hospital performance, including revenues, volume and composition of services, productivity, wages, case mix, and administrative behavior. Because the effects of prospective reimbursement may be felt beyond the hospital sector, the study will also examine impacts on the costs and utilization of the health care system as a whole.

This volume is one of nine case study reports (Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, Washington, and Western Pennsylvania). Each report examines in detail the adoption, implementation, review processes and legal challenges of each prospective reimbursement system. In addition, the reports examine linkages and interactions that take place between rate-setting agencies and other organizations such as planning groups, hospital associations, third party payors, and unions. Each case study also presents a preliminary analysis of the potential rigor and equity of the prospective reimbursement system. (A separate report, A Comparative Analysis of Nine Prospective Reimbursement Programs, analyzes all nine programs simultaneously along these factors.) The case study reports will be most useful to those interested in a detailed description of the prospective reimbursement programs in the nine states under study.

The preliminary analyses of rigor and equity in the case studies are interim in nature. Data collection on hospital performance is still ongoing and will yield important information about the effectiveness of administrative structures and procedures in containing costs and delivering quality service. Final results of the study are expected in 1982.

Diane E. Hamilton
Deputy Project Director &
Director of Case Studies
National Hospital
Rate-Setting Study

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*Arthur D. Little, Inc. and Arthur Andersen & Co. are also participating in the National Hospital Rate-Setting Study but were not involved in the case studies.

INTRODUCTION

General Summary and Scope of the Washington State Prospective Reimbursement Program

The current prospective reimbursement system in Washington is a mandatory budget review system, with payment rates calculated for the participating payors--Medicare, Medicaid, Blue Cross, and Labor and Industries--under three mechanisms: a portion of the approved budget, a percentage of charges, and regular retrospective reimbursement. The budgets are ultimately approved by the Washington State Hospital Commission (WSHC), created by legislation passed in 1973, and are subject to year-end compliance. While budget review was first implemented in the fiscal years beginning on or after October 1, 1975, calculation of actual payment rates did not start until fiscal years beginning on or after July 1, 1977, when Washington State received a demonstration grant from the Health Care Financing Administration to institute an experiment to compare the effect of the three different payment mechanisms. While budgets were reviewed and year-end compliance was conducted prior to this time, the rates approved applied only to charge-based commercial payors, self-payors, and the state's Workmen's Compensation program. The current system reviews budgets based on a three-tier screening mechanism for departmental expenses and revenues; those hospitals failing the first tier of screens are subject to the second tier and ultimately to the most detailed level of screening. Unless the hospital can justify excess expenses or revenues over the 70th percentile of its peer group, the staff generally recommends to the Commission that these amounts be disallowed.

The following subsection briefly describes some characteristics of the Washington hospital industry and trends in these characteristics over time. The second section discusses the incentives leading to adoption of the system and program changes since its inception. A detailed discussion of the current system is provided in the third section. The fourth section describes interactions between the rate-setting authority and other agencies and organizations in the industry, and the final section presents a discussion of the rigor, incentives, and equity in the system by focusing on its structure and process.

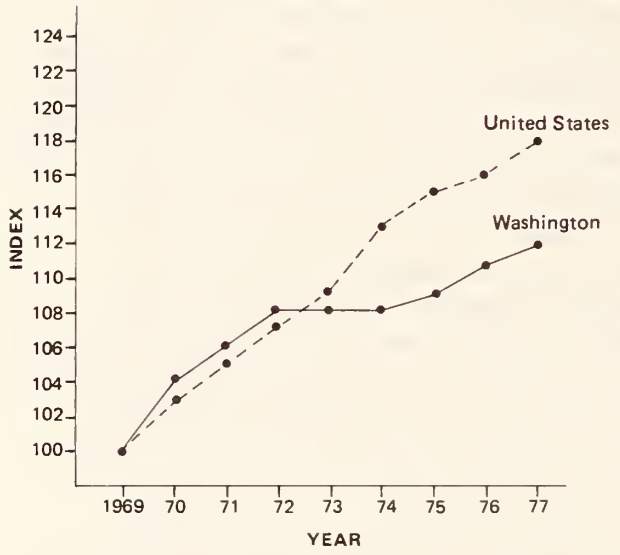
Trends in Washington State Hospital Industry

Washington state is characterized by a slower rate of growth relative to the nation of both beds and patient days for the years 1969 to 1977 (see Figure 1). Furthermore, both length of stay and occupancy are substantially lower in Washington state than nationally, although both the state and the nation have experienced the same (decreasing) trends over time for these two variables.

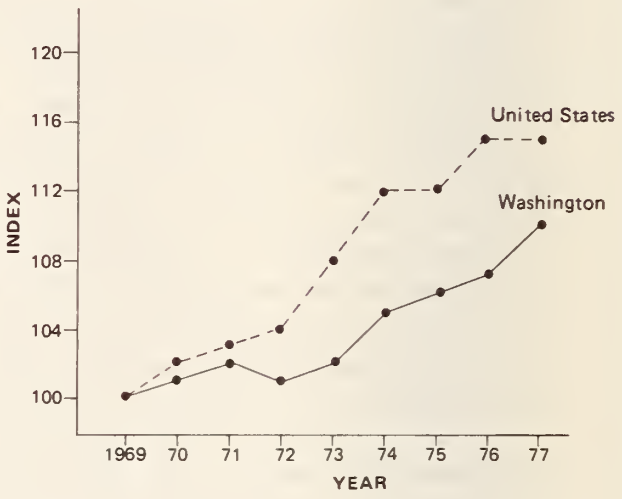
Figure 1

COMPARISON OF HOSPITAL INDICATORS:
Capacity, Volume of Service and Utilization
for Community Hospitals, 1969-1977
WASHINGTON vs. U.S.

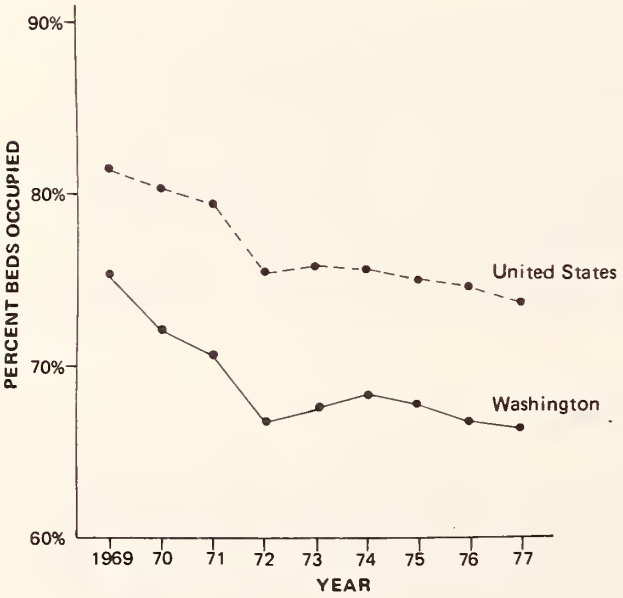
INDEX OF TOTAL BEDS
(1969 = 100.0)



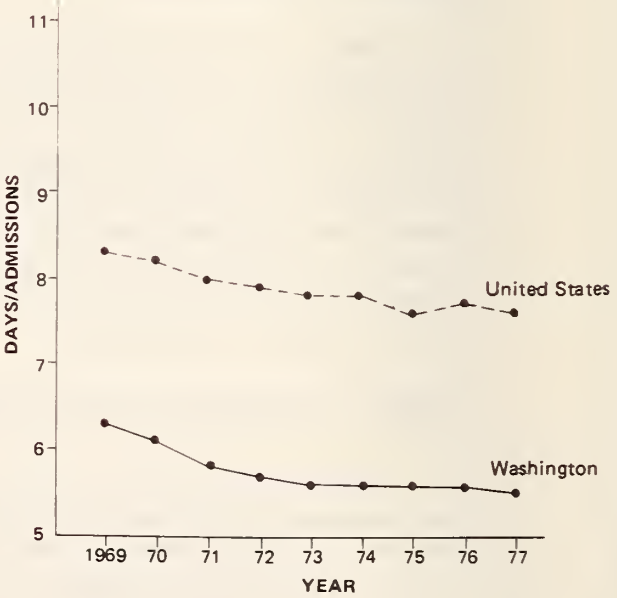
INDEX OF ADJUSTED PATIENT DAYS
(1969 = 100.0)



AVERAGE OCCUPANCY RATES



AVERAGE LENGTH OF STAY



In terms of revenues and expenses (see Figure 2), Washington state seems to have followed the same pattern over time as the nation; both expenses per patient day and revenues per patient day showed the slowest rate of increase in 1974, which was the last year of ESP. Although Washington state expenses and revenues were slightly below the nation's, they appear to have caught up in 1977.

In terms of expense per capita, Washington state has shown the same growth pattern over time, although in absolute terms, expense per capita is lower in Washington state than nationally.

Finally, assets per bed were higher in Washington state, and over time, show a higher rate of increase than that for the nation, particularly in 1975 and 1977. In summary, Washington state generally experienced the same trends over time as the nation from 1969 to 1977, although its absolute levels are generally lower in the categories of occupancy and length of stay. The one exception is assets per bed, as noted above.

ADOPTION

Pressures Leading to Adoption

The pressure for regulation of hospital costs in the State of Washington may be traced back to the grass roots of the state's labor movement. Concerned that costs for hospital care were increasing more rapidly than accompanying benefit packages could be negotiated, local labor councils requested that the Washington State Labor Council investigate the problem. After exploring the factors that precipitated the increase in hospital costs, the State Labor Council (representing essentially the AFL-CIO unions in the state) concluded that hospitals should be viewed as utilities with respect to the rates they charged.[1] Since labor did not have the leverage to control the rising costs of health care, the creation of a public agency to represent the public interest seemed the most logical solution.

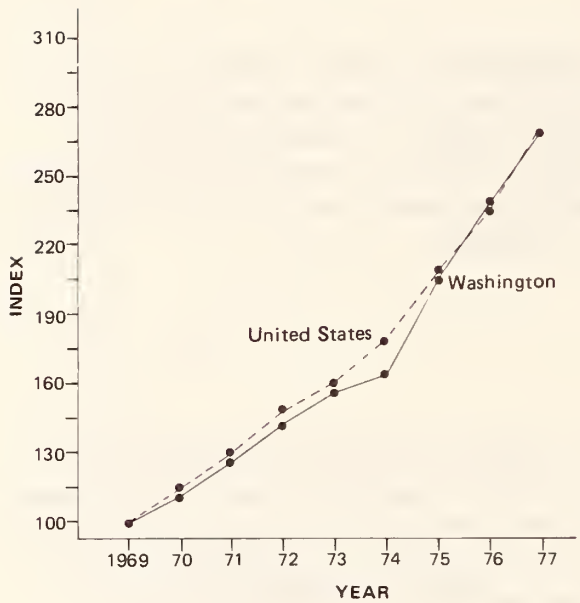
The United Labor Lobby sponsored two Senate bills in 1969, which proposed the creation of a hospital rate commission. Both bills were successfully challenged by the Washington State Hospital Association (WSHA) and the state's Medical Association. However, a resolution authorizing the Senate's Legislative Council to conduct a study of health care costs was passed. At this time, a number of major third-party payors also began to express concern over spiraling hospital charges. Federal and state agencies responsible for payments under the Medicare and Medicaid programs and the State Workmen's Compensation Medical Aid Program faced costs that were in

[1]The State of Washington has a long history of utilities regulation.

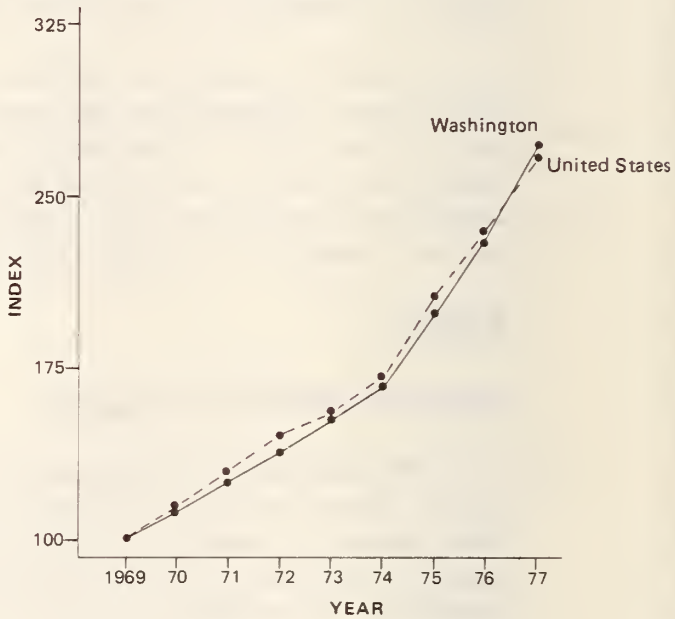
Figure 2

COMPARISON OF HOSPITAL INDICATORS:
Expense, Total Revenue and Assets
for Community Hospitals, 1969-1977
WASHINGTON vs. U.S.

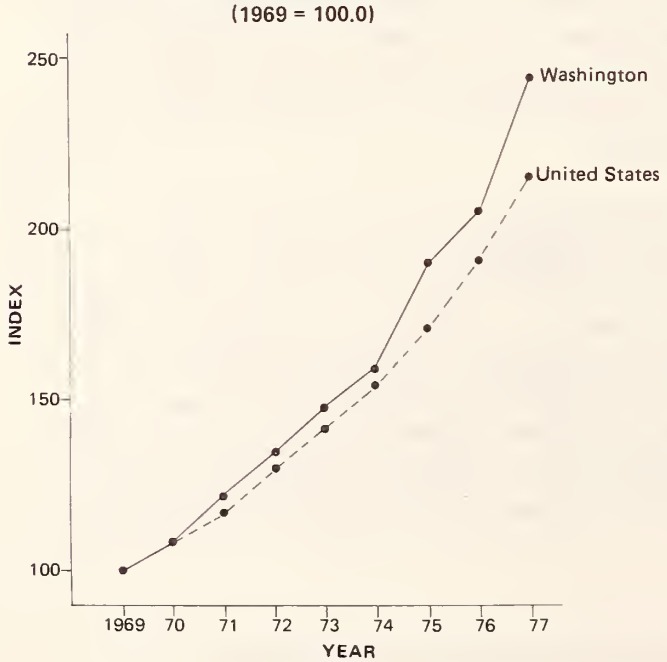
INDEX OF HOSPITAL EXPENSE PER DIEM*
(1969 = 100.0)



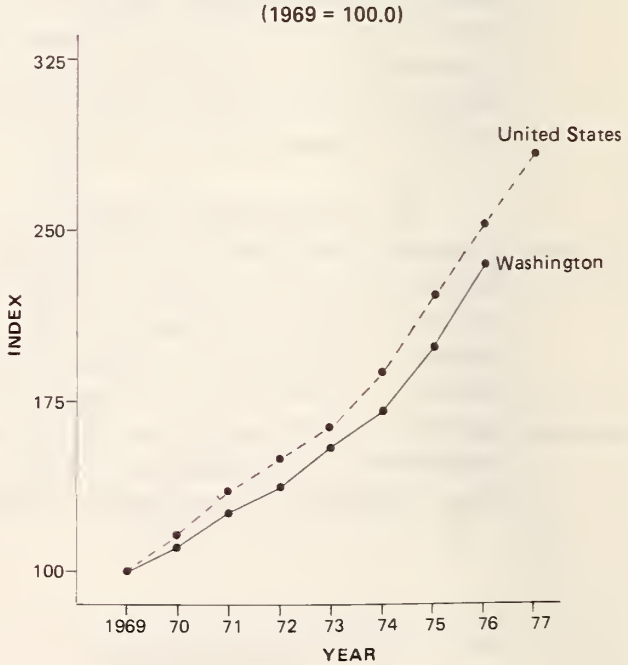
INDEX OF TOTAL HOSPITAL REVENUE PER DIEM*
(1969 = 100.0)



INDEX OF ASSETS PER BED
(1969 = 100.0)



INDEX OF HOSPITAL EXPENSE PER CAPITA
(1969 = 100.0)



*Per adjusted patient day.

excess of state appropriations and thus created serious deficit problems.[1] By 1971, another hospital rate commission bill was introduced by the Chairman of the Senate Health Committee. The bill was again tabled, but as a result of hearings on the bill, the Legislative Council resolved to continue studying the issue during the next interim.[2]

It was at this time that the Washington State Hospital Association indicated its willingness to cooperate in the drafting of a bill that would be acceptable to hospitals because the hospital industry had begun to feel the escalation of input prices and limitations on third-party payment. Although the nationwide Economic Stabilization Program had started in 1971, offering hospitals some relief from mounting input costs, ESP accentuated the problem of recouping revenue lost through third-party contractual allowances.[3]

More importantly, the WSHA saw some type of regulation as inevitable. Given that length of stay in Washington State was already substantially lower than that in the nation, with the result that per diem costs might appear disproportionately higher for the state, state regulation seemed preferable to subjection to federal controls. The Association therefore decided to assume a leading role in the drafting of the legislation and regulations. When legislation to establish a hospital rate-setting bill was introduced in 1973, the bill passed with no opposition.[4] Key elements lobbied for by the Association survived intact, including an independent commission rather than a state agency, a requirement that one commissioner have expertise in hospital administration, and recognition of the total financial needs of the hospital.

Evolution of the Washington State System

Figure 3 shows the progression of major developments that occurred in the system from 1973 through 1976, when the Commission was awarded a research contract by the Health Care Financing Administration to incorporate actual calculation of payor reimbursement into the system. The Washington statute called for the development and implementation of a statewide system of accounting, reporting, and budgeting no later than two and one-half years from the date of the Commission's formation. The statute required that

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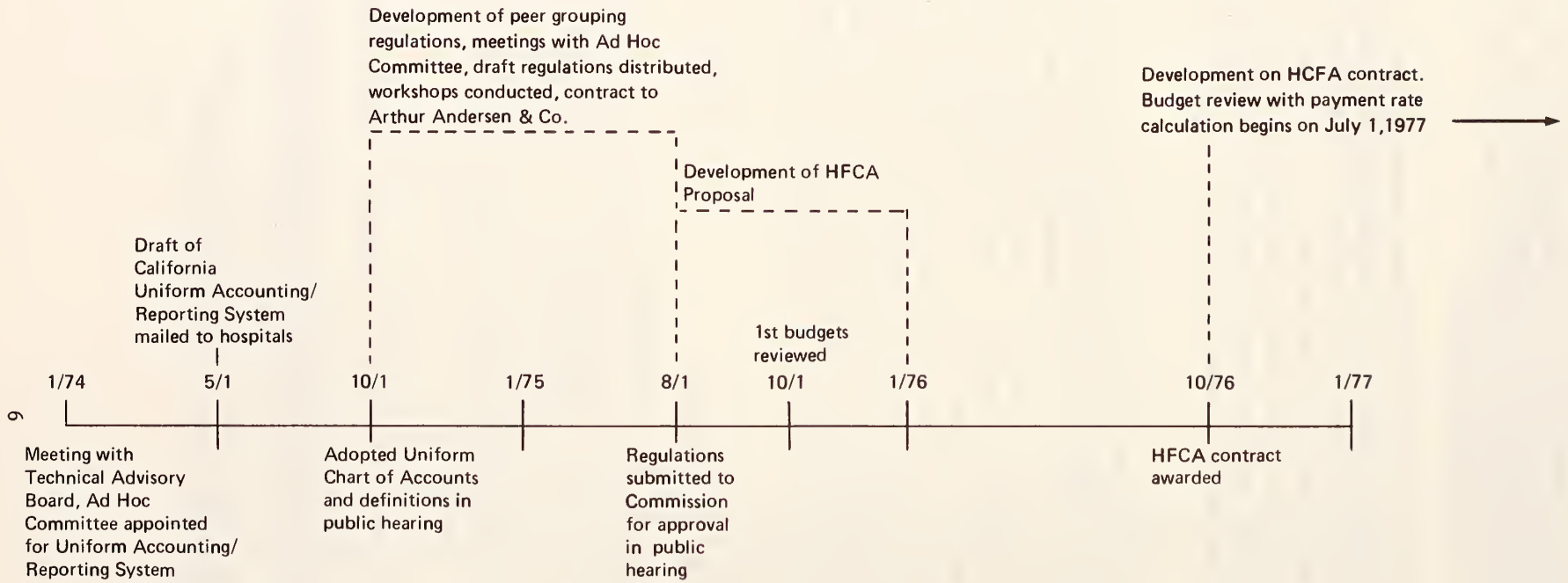
[1] F. Baker, "Prospective Rate Setting," Topics in Health Care Financing, Volume 3, No. 2, Winter 1976.

[2] J.B. Welsh, Jr., The Legislative Development of the Washington State Hospital Commission Act, Paper presented before the Governor's Blue Ribbon Committee on Health Care, State of Idaho, Sept. 17, 1976.

[3] Health Rate Regulation Cost Containment Series, Washington State Prospective Rate Setting System, Ernst & Ernst (April 1978).

[4] See Appendix A.

Figure 3
MAJOR DEVELOPMENTS IN WASHINGTON SYSTEM


Development of peer grouping regulations, meetings with Ad Hoc Committee, draft regulations distributed, workshops conducted, contract to Arthur Andersen & Co.
Development on HCFA contract. Budget review with payment rate calculation begins on July 1,1977
Development of HFCA Proposal
Draft of California Uniform Accounting/ Reporting System mailed to hospitals
1st budgets reviewed
1/74
5/1
10/1
1/75
8/1
10/1
1/76
10/76
1/77
Meeting with Technical Advisory Board, Ad Hoc Committee appointed for Uniform Accounting/ Reporting System
Adopted Uniform Chart of Accounts and definitions in public hearing
Regulations submitted to Commission for approval in public hearing
HFCA contract awarded

the system be phased in prior to the prospective review of budgets and rates by the Commission. The first task undertaken by the Commission when it began operation in January of 1974, the development of the accounting and reporting system spanned fifteen months. An ad hoc subcommittee of the Technical Advisory Committee (TAC) was established to assist in the evaluation of existing systems and the development of a system for Washington. Several drafts were proposed, workshops were conducted, and consultations were held with hospital representatives. The Uniform Chart of Accounts and Definitions, modeled closely after the California system, was adopted by the Commission and approved October 1, 1974; the system became effective for those hospitals with fiscal years beginning on or after October 1, 1975. Although the Commission originally planned on using 1974 as the baseline year, this plan was not found to be viable because hospitals were unable to reclassify financial data from their former system to meet the report requirements designed by the Commission.[1]

The design and implementation of a uniform budgeting and rate-setting system, and the development of a hospital classification system, were the focus of the Commission's activities for the remainder of 1974 and 1975. Although review of limited charges was considered, this would not have been consistent with the Commission's statutory mandate. That is, the Commission was charged with establishing a system that assured a reasonable relationship among services, costs, and rates while providing for the total financial requirements of each hospital. In the early spring of 1975, the Commission, through a request for proposals, contracted with Arthur Andersen & Co. for the development of a uniform budgeting system. A team of consultants worked with the Commission staff and the Technical Advisory Committee throughout the spring and summer, developing a budgeting system that had as its basic foundation a uniform accounting system. Drafts were circulated, workshops conducted, and public hearings held to assure that all concerned parties could learn about the proposed system. By April of 1975, the Commission adopted by regulation a budgeting system that first became effective for hospitals with fiscal years beginning on or after October 1, 1975.[2]

During this same time frame, Commission staff began developing a hospital classification system; classifying or grouping hospitals was considered a key concept required by statute. Specifically, the enabling legislation required that the Commission provide a number of "assurances" to the general public in carrying out its mandate. These included:

- assurance to the public that hospital costs are related to hospital services and that rates are reasonably related to aggregate costs; and that

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[1] K. Bauer, Health Insurance Studies: Contract Research Series, Report No. 1, Volume 7, p. 14, 1977.

[2] F. Baker, op. cit; Commission regulations are found in Appendix B.

- consideration be given to the similarities among hospitals, as well as the differences between hospitals, in reviewing budgets and rate-setting requests.[1]

The grouping mechanism developed by the Commission is described in the content and process section. The concept underlying the classification system recognizes cost differences between hospitals and groups of hospitals, based on a set of factors considered to influence hospital costs.

Hospitals submitted budgets for review in October of 1975. Prior to this, a number of months were spent designing the mechanics of the budget review process, which also entailed design of a software computer package to complement the system designed. Several criteria were used by the Commission as they developed the budget review process. First, the initial focus of the review was to be on hospitals exhibiting "high" costs; therefore, a detailed line-item review process was not envisioned. Second, the Commission had to design a review process that could initially be implemented by its support staff of seven professionals and two secretaries. In order to accommodate these constraints as well as meet the guidelines defined in the Commission statute, an exceptions review process was implemented. Using a screening system, budgets requiring more detailed analysis, i.e., those of high-cost hospitals, were identified, while hospitals with lower costs did not undergo extensive, detailed review.[2]

In 1976, the Washington State Commission was awarded a contract by the Social Security Administration to conduct a three-year study to test and compare three reimbursement methods. The implementation of this study represents the major change made in the Washington system since its inception in 1974. The study, now administered by the Health Care Financing Administration, paved the way for multi-payor participation in the Washington system. The Commission established a demonstration project, which included Blue Cross, Medicaid, Medicare, and the Department of Labor and Industries; each payor agreed to reimburse hospitals at rates approved by the Commission. Hospitals were divided into three experimental groups: two groups to be reimbursed on a prospective basis and the third group on a retrospective basis, thus serving as a control group. Hospitals were first phased into this system, which is described in detail in the content and process section, in July of 1977.

It should be noted that, while Medicare has participated in the reimbursement experiment since fiscal 1978, a blanket waiver was not obtained until the fall of calendar year 1978. However, Medicare has waived the lower of costs or charges requirement, the routine care limit, the charity

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[1]F. Baker, op. cit.

[2]F. Baker, op. cit.

exclusion, and other elements since the award of the HCFA contract. Under the waiver agreement, there is a potential retrospective cap on Medicare reimbursement. The percentage increase in Medicare expenditures per beneficiary for the entire state will be compared to the percentage increase per Medicare beneficiary nationwide, and any amount greater for the state in these percentage increases must be paid back to Medicare. However, the preliminary methodology for calculating the amount of payback on an individual hospital basis assesses the amount of payback based on Medicare utilization in each particular hospital, whether the particular hospital was or was not responsible for the excess. Thus, each hospital in the state with prospective rates may be at risk regardless of its particular cost-containing activities.[1]

The imposition of this cap on the PR system complicates evaluation, since it is unclear to which constraint (that of the PR program versus that of the retrospective Medicare cap) hospitals are responding.

CONTENT AND PROCESS

Organization of the Washington State Hospital Commission

The Washington State Hospital Commission currently is comprised of five members: one consumer representative who serves as chairman, one physician, one labor representative, one business person, and one hospital industry representative (who is replaced by an osteopathic hospital representative when an osteopathic hospital is being reviewed). The Commissioners are appointed by the Governor for four-year staggered terms. While it might be assumed that each Commissioner would vote according to a vested interest, there is a strong commitment on the part of all Commissioners to vote independently. The skills and knowledge that the Commissioners bring to the budget review process from their diverse backgrounds are brought to bear in their deliberations.

Under the Washington State statute, provision was also made for the establishment of a Technical Advisory Committee (TAC) to advise the Commission on policy matters and provide comments on health care cost studies.[2] Some of the issues recently considered by TAC have included funding for future capital items, inclusion of a technology factor in future capital requests, dealing with prior year's unfunded depreciation, and improvements in the statistics currently used for departmental output. The committee consists of eleven members appointed by the Governor and meeting the following criteria:

- one Certified Public Accountant knowledgeable in hospital finance;

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[1]This methodology has not been finalized at the time of publication.

[2]Ernst & Ernst, "Washington State Prospective Rate Setting System, Health Rate Regulation/Cost Containment Series, April 1978.

- one health care practitioner, state licensed and knowledgeable in hospital administration;

- five members representative of investor-owned, district (or public), not-for-profit, osteopathic, and university hospitals;

- one representative of consumers of health care;

- the Secretary of the Department of Social and Health Services, or the Secretary's appointee, to provide a continuing liaison with relevant Department functions;

- the Director of the Planning and Community Affairs Agency, or the Director's appointee, to provide continuing liaison with the Comprehensive Health Planning Council; and

- one Commission member elected to the Committee by the Commission.

The TAC chairperson and vice-chairperson are elected by the TAC membership. Additionally, the executive director of the Commission serves as executive secretary to the advisory committee. The Commission is also supported by four ad hoc committees charged with supplementing the resources provided by the TAC in specialized fields related to the functions of hospitals. There are currently four ad hoc committees in the following areas:

- prospective reimbursement,

- education of professionals,

- return on investment for proprietary hospitals, and

- cooperation with physicians.

The Commission is also supported by a full-time staff, who perform the detailed budget review and analysis and make recommendations to the Commission at the time of its meeting. This staff is composed of a director, deputy director, and executive secretary appointed by the Commission, and originally, seven other staff. As a result of the Section 222 rate-setting experiment authorized by the Health Care Financing Administration of HEW, the staff currently consists of fifteen persons. Figure 4 illustrates the current organizational structure of the Commission.

Figure 4
ORGANIZATION OF THE WASHINGTON STATE HOSPITAL COMMISSION

NOTES

1: Deputy Director – currently on I.P.A. loan to HEW, will return on July, 1980.

2: Deputy Director – position will terminate on July, 1980.

3: Rsrch Invstgtr 2 – project position to be filled January, 1980.

4: Rsrch Analyst – project position to be filled February, 1980.

5: Mgmt Analyst 2 – staff position to be filled July, 1980.

6: Adm Intrn 2 – temporary position that is filled a maximum of four months each year.

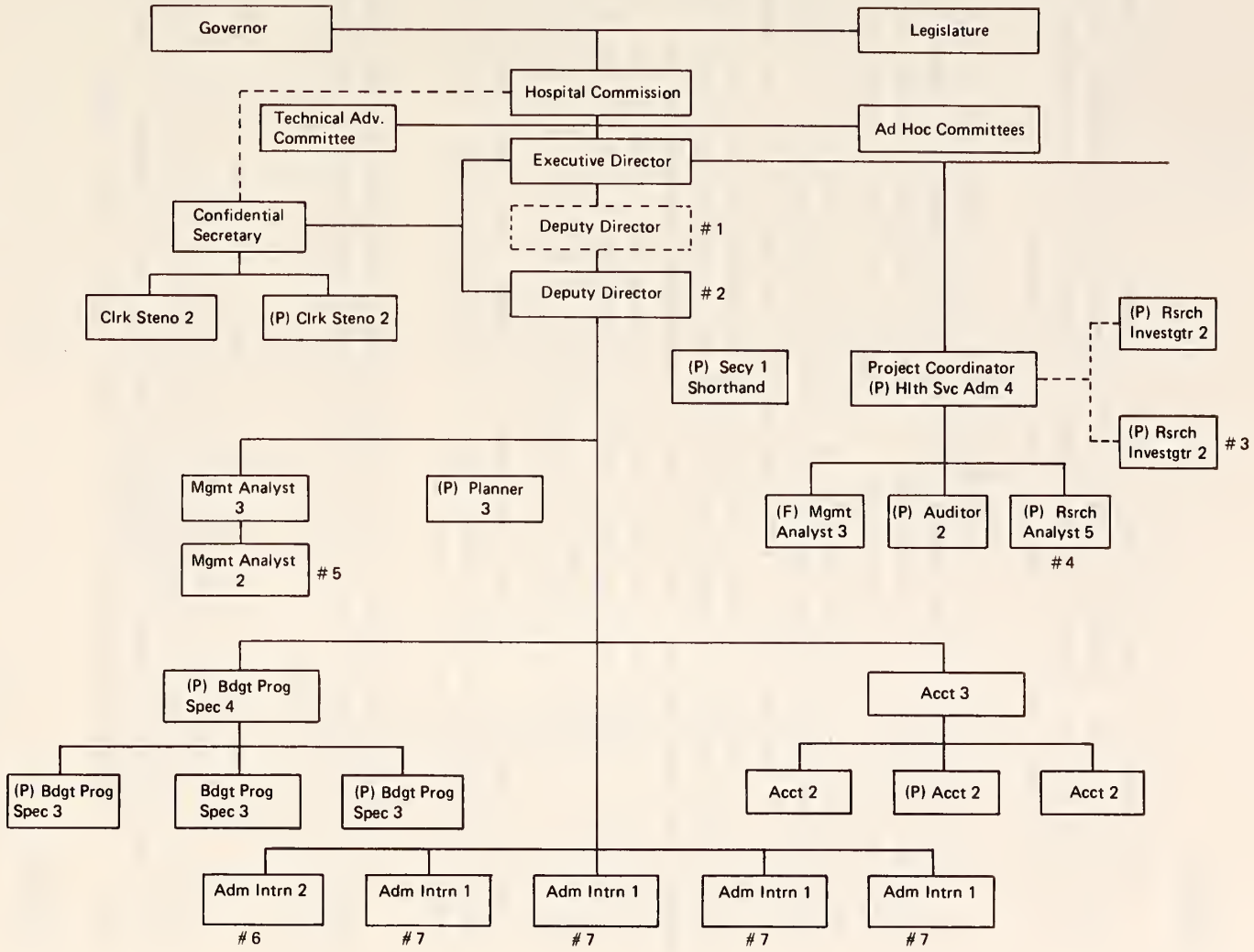
7: Adm Intrn 1 – project positions on a temporary basis thru October, 1979.

Other

A) Those positions indicated by a (P) are project positions.

B) Upon project completion the following positions will terminate; all others will become staff positions:

1 Hlth Svc Adm 4	1 Planner 3
2 Rsrch Invstgtr 2	1 Mgmt Analyst 3
1 Rsrch Analyst 5	1 Auditor 2



Source: Washington State Hospital Commission

Timing

The timing of any hospital's budget review depends on the hospital's fiscal year. For example, a fiscal year beginning on January 1 can be used to illustrate the timing of the system. Figure 5 shows a typical time line for the budget review process in Washington state.

The Commission staff receives the hospital budget sixty days prior to the beginning of the rate year. The next thirty days are spent reviewing the hospital's budget, i.e., desk audit, profile analysis, volume analysis, and comparison with established screens. During this time, anything in the submitted budget that is unclear to the staff is resolved with the hospital. Approximately thirty days before the rates go into effect, the staff issues a report to the hospitals, the Commission, the Health Systems Agencies, and third-party payors on their findings and recommendations. Approximately three weeks before the rates go into effect, a public hearing is held before the Commission. At this time, Commission members review recommendations by the staff and may query the hospital on any area of hospital operations. Also, at this time, the hospital may argue for certain areas of operation in which the staff has recommended a budget cut. Finally, the Commission votes on the staff recommendations and the final approved budgeted revenue. A formal Decision and Order (D&O) detailing the final approved revenue is then issued by the Commission, approximately one week before the rates go into effect.

These approved rates are in effect until the next fiscal year begins; however, the hospital may request an interim adjustment in its rates at any time during the year on the basis of volume changes or changes in operations.

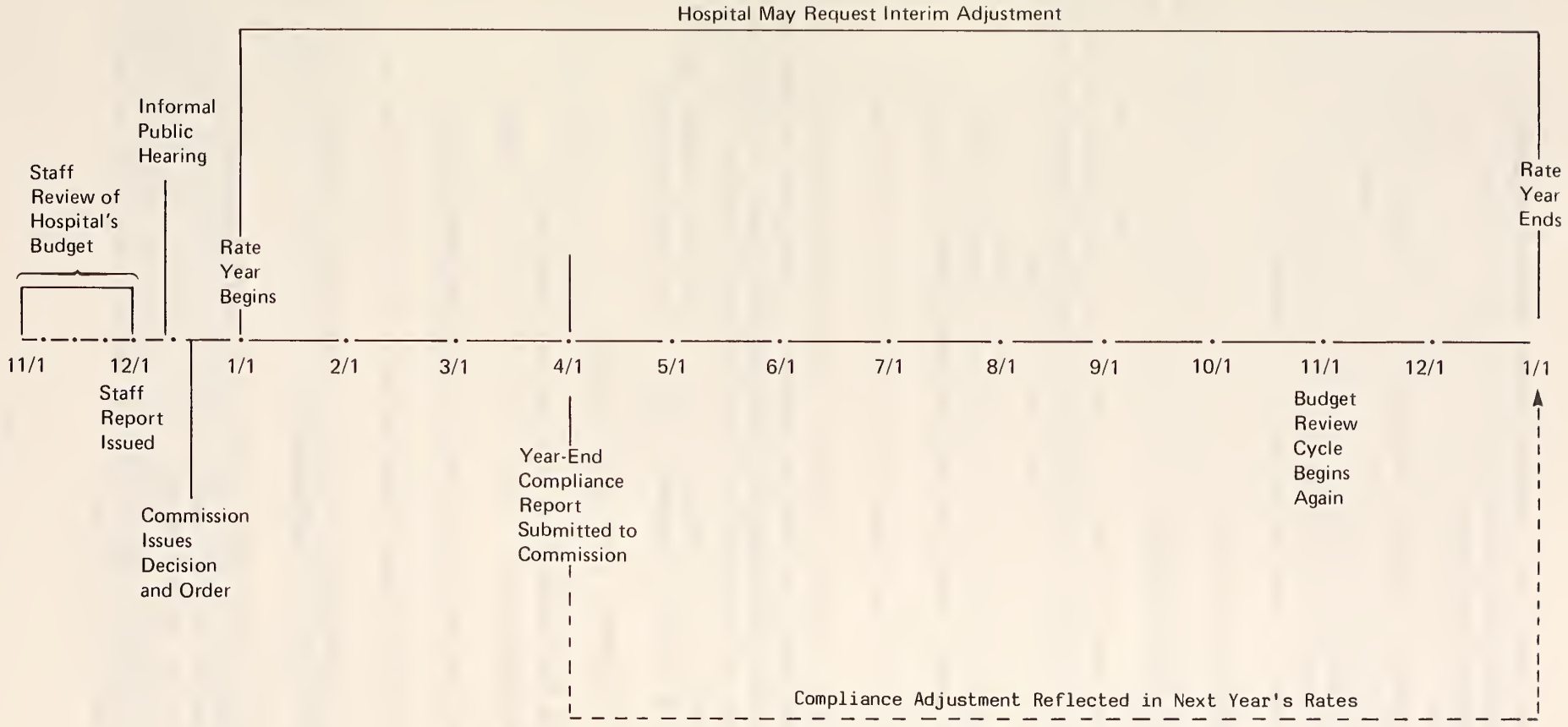
About four months into the current year, the Commission receives actual audited data from each hospital for the previous year. At this point, year-end compliance is assessed, and this compliance amount is incorporated into the following year's allowable revenue. In November of the current year, the budget review cycle for the next year begins again.

Process

Allowable Costs

The policy of the Washington Commission is for hospitals to receive their total financial requirements, which can be separated into three general areas: operating expenses, deductions from revenue, and a Planned Capital and Service Component (PCSC). In Washington, operating expenses include the usual categories of salaries, wages, and supplies, as well as such items that are generally considered nonoperating expenses by other systems, such as depreciation and interest. Specifically, operating expenses include the following.

Figure 5
TYPICAL TIME LINE FOR BUDGET REVIEW CYCLE



- direct operating expenses broken down by natural classification (salaries, wages, fees, fringe benefits, supplies);
- net patient-related research;
- net education costs;
- historical cost (straight-line) depreciation;[1]
- long-term debt; and
- rental/lease expense.

The Commission also considers certain deductions from revenues as part of total financial requirements and incorporates them into allowable reimbursement. Deductions from revenue include the following:

- costs associated with contractual allowances from Blue Cross, Medicare, and Medicaid;[2] and
- charity and bad debt.

In addition to these allowable expenses, the Commission's policy is that allowable expenses should include the expenses of new construction and expansion, as well as improvements to the physical plant. Accordingly, the Commission adds to the baseline of the hospital's budget (i.e., that which is not subject to peer group review) an additional amount called the Planned Capital and Service Component (PCSC). The PCSC includes:

- net increases in working capital,
- funds for feasibility studies and planning of shared services,
- expansion and acquisition of new equipment, and
- prior debt payment commitments.

These three major components serve as the Commission's definition of the hospital's total financial requirements.

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[1]Includes building, plant, fixed, and major movable equipment.

[2]Contractual allowances are allowances that take into account certain costs attributable to certain payors, such as special reporting requirements, utilization review, and credit and collection. These allowances (or discounts) are computed by the Commission and are described in detail in the section on the review process.

The Budget Review Process

Data Analyzed. In reviewing a hospital's budget, data from three time periods are examined. These include historical data for the year two years prior to the budget year (prior year), six months' actual and six months' projected data for the current year, and projected data for the budget year. These data are subject to screens and comparisons, both over time within the same hospital and in comparison with other hospitals within peer groups.

Peer Grouping. The peer grouping mechanism used by the Washington Commission is a cluster analysis approach based on two sets of variables. The first group of variables (endogenous) proxy the output or product of the hospital and include:

- available beds,
- profit/nonprofit status,
- government/nongovernment sponsorship,
- accredited/nonaccredited status,
- weighted service index,[1]
- physician-mix index (number of specialties),[2]
- number of interns,
- number of intern specialties,
- number of residents,
- number of resident specialties,
- percent Medicaid days, and
- percent Medicare days.

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[1]This service index is based on forty-eight services, weighted by their costliness. The index was developed by W. Dowling, University of Washington.

[2]Various weightings of physician mix were tried; however, none yielded a higher degree of variation explanation than simply the number of specialists.

The second group of variables (exogenous) proxy market and service area factors and include:

- number of physicians per 1000 population,
- number of hospital beds per 1000 population,
- percent female population of 15 to 44 years,
- percent population 65 years and older,
- percent urban population, and
- median income.

These variables were used in a cluster analysis that produced five peer groups and one unclassified group. The six groups are generally described in Table 1.

The Review Process. The Washington Commission has adopted a policy of focusing on those hospitals that exhibit apparently high costs, rather than a detailed line-item review of each budget submitted. Accordingly, the Commission has implemented an exceptions review process, which identifies potentially high-cost operations and allows hospitals with apparently lower costs to be approved without a detailed analysis.[1] Those hospitals that do not pass the first screening analysis then go through a secondary, more detailed analysis. The process can be generalized into seven key steps, which include:

- initial profile analysis,
- volume analysis,
- operating expense (primary and secondary screens),
- additional financial requirements (including financial analysis),
- deductions from revenue,
- analysis of rates and cross-subsidization, and
- performance analysis.

[1] F.D. Baker, "Prospective Rate Setting in Washington State," Topics in Health Care Financing, Winter 1976.

TABLE 1: Description and Number of Hospitals by Peer Group

Peer Group	Description	Number of Hospitals
1	Primary services, rural, nonaccredited, 16-60 beds	24
2	Primary services, rural, accredited, 16-60 beds	24
3	Primary and secondary services, limited tertiary services, metropolitan, suburban hospitals, about 110 beds	24
4	Primary and secondary services, some tertiary services, about 180 beds	21
5	Tertiary services: teaching, research, advanced medicine	10
6	Unclassified or special services, e.g., psychiatric, alcoholic, HMO, and surgical.	12

Source: Ernst and Ernst, "Washington State Prospective Rate Setting System," Health Rate Regulation/Cost Containment Series, April, 1978.

1. Initial Profile Analysis

The initial profile analysis is performed to determine whether there have been any significant changes in the overall hospital operations and market area that might have an impact on the hospital's budget. This includes any changes in factors such as available beds, service mix, numbers and depth of specialization, and hospital organization, and then cross-references these changes with the goals and objectives of the hospital. The analysis also looks at exogenous variables, such as area population, to determine whether changes in the hospital's market area have occurred.

2. Volume Analysis

The volume analysis looks at trends in various hospital statistics such as patient days, admissions, length of stay, and occupancy, as well as in more disaggregated statistics, such as daily hospital service[1] output and ancillary outputs. Inpatient versus outpatient volumes are also considered. Seasonal patterns are considered and hospital statistics are compared with the utilization projected by the various HSAs.[2] The purpose of the volume analysis is to determine what past trends have occurred and whether the utilization projected by the hospital is reasonable.

3. Operating Expense[3] (Primary and Secondary Screens)

There are two screening stages, each with a subsequent explanatory analysis. The primary screens examine total budgeted expense per admission (ADM) and adjusted patient day (APD), both in absolute and percentage increase terms. Specifically, the screens examine the following areas:

the absolute value of:

- total budgeted operating expense/APD and
- total budgeted operating expense/ADM, and

the percentage change in the above from:

- current year (estimated) to budget year and

[1] Intensive, acute, and necessary care.

[2] The interface between the Commission and the various HSAs is discussed in detail in the section on interactions.

[3] In examining the various elements of projected expenses, the Commission does not set a strict inflation index that it will allow. Rather, the hospital (in its submitted budget) assumes certain inflationary amounts in the input prices it will pay.

- current year (approved[1]) to budget year.

To pass the primary screens for any of the above, the hospital's budget must fall at or below the 70th percentile. If the budget passes the primary screen, the hospital goes on to the next step in the review process, deductions from revenue; if the budget does not pass any of the primary screens, a further explanatory analysis is conducted, which focuses on natural and functional expense categories. The following ten natural categories of cost are examined on both an adjusted patient day and an admission basis:

- total salaries, wages, and employee benefits;
- total salaries and wages;
- total professional fees;
- total supplies expense;
- total purchased services expense;
- total depreciation, leases and rentals;
- total leases and rentals;
- total interest expense;
- interest expense on working capital; and
- adjusted expense (operating expense less depreciation and interest).

In addition, the first two items, as well as the last item, are examined for percentage increases from current to budget year. This analysis points to particular natural expense categories that may be the causes of failure to pass the primary screens.

In addition, for each of three functional cost areas (daily hospital services, ancillary services, and supporting services), total operating expenses alone, as well as per admission and per adjusted patient day, are examined in terms of projected budget levels and percentage increases from current to budget year. This analysis is performed to determine which functional areas are contributing to the primary screen failure.

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[1]By "approved" is meant the amount approved by the Commission in the previous budget year.

The secondary screens fall into two broad categories: cost center expense screens and cost center natural expense, productivity, input price, service intensity, and utilization screens.

a. Cost Center Expense Screens

The purpose of these secondary screens is to determine which cost centers within a functional area are contributing to the primary screen failure. Total cost center operating expenses per unit of departmental output are examined in terms of projected budget year level and percentage change from current to budget year. In addition, total cost center operating expenses are examined in terms of percentage change from current to budget year and percentage change from current (approved) to budget year. The cost centers and outputs used are shown in Table 2. If the hospital is above the 70th percentile on any of these measures, it is subjected to a "detailed" screen.

b. Detailed Screens

The purpose of the detailed screens is to determine, through analysis of cost, productivity, input prices, intensity, and utilization, the way any specific cost center is failing the secondary screens. Table 3 shows the various areas that are screened for each cost center that fails the secondary screens.

In examining the various elements of projected expenses, the Commission does not set a strict inflation index that it will allow. Rather, the hospital in its submitted budget assumes certain inflationary amounts in the input prices it will pay.

4. Additional Financial Requirements (including Financial Analysis)

As mentioned earlier, the Planned Capital and Service Component (PCSC) allowed by the Commission includes net increases in working capital, acquisition funds for feasibility studies, prior commitments, and expansion and acquisition of new equipment. However, this last item is analyzed for the appropriate amount to be allowed, according to the following formula:

> projected annual depreciation expense minus the cost of replacement equipment plus the cost of new equipment approved by the Planning Agency (or in the case of equipment under $100K, approved by the Commission).[1]

[1]If the entire amount were approved, it would mean that, while capital needs in excess of depreciation are reimbursed, this amount is decreased to the extent that current depreciation does not cover the cost of replacement equipment.

TABLE 2: Secondary Screening: Cost Center Breakdown and Units of Measure

COST CENTER BY FUNCTIONAL AREA	UNIT OF MEASURE
Daily hospital services:	
• intensive care	• patient day
• acute care	• patient day
• nursery	• newborn day
Ancillary services:	
• labor and delivery	• delivery
• surgical services	• operating minute
• central services (CS)	• CS-adjusted patient day[1] and adjusted admissions
• laboratory	• billable CAP unit[2]
• radiology	• relative value unit
• pharmacy	• pharmacy-adjusted patient day[1]
• respiratory therapy	• treatment
• emergency	• visit
Supporting services:	
• dietary and cafeteria	• equivalent meal
• laundry	• dry pound
• plant	• square foot
• housekeeping	• square foot
• fiscal services	• adjusted admission
• administrative services	• adjusted admission
• medical records	• adjusted admission

[1]Computed in general terms as:

$$\text{Cost Center Adjusted Patient Days} = \text{Patient Days} \times \frac{\text{Cost Center Total Revenue}}{\text{Cost Center Inpatient Revenue}}$$

[2]Units established by the College of American Pathologists.

Source: Ernst and Ernst, "Washington State Prospective Rate Setting System," Health Regulation/Cost Containment Series, April 1978.

TABLE 3: Secondary Screens - Detailed Level Variables

a. Costs Per Unit of Service Salaries and wages and employee benefits per unit of measure as an absolute value. Salaries and wages per unit of measure as an absolute value. Professional fees per unit of measure as an absolute value (certain ancillary and supporting services cost centers only). Supply expense per unit of measure as an absolute value. Supply expense per unit of measure as a percent change from current year. Purchased services per unit of measure as an absolute value (ancillary and supporting services cost centers only). Depreciation expenses per unit of measure as an absolute value. Allocated expenses per unit of measure as an absolute value (daily hospital and ancillary services cost centers only). All other operating expenses per unit of measure as an absolute value.	c. Measures of Labor Input Prices Salaries and wages and employee benefits per FTE as an absolute value. Salaries and wages and employee benefits per FTE as a percentage change from current year estimated actual. Salaries and wages per FTE as an absolute value. Salaries and wages per FTE as a percentage change from current year estimated actual. d. Measures of Service Intensity Units of service per adjusted admission as an absolute value (certain ancillary and supporting services cost centers only: labor, surgery, laboratory, radiology, respiratory therapy, emergency, dietary and laundry). e. Measures of Utilization Percentage occupancy (intensive care and acute care cost centers only).
b. Measures of Labor Productivity Total paid hours per unit of measure as an absolute value. Total paid hours are simply the product of the value of the scaler, 2,080 maximum paid straight time hours per FTE, times the number of FTEs. The scaler is applied to avoid very small values for the labor productivity variable.	

Source: Ernst and Ernst, "Washington State Prospective Rate Setting System," Health Rate Regulation/Cost Containment Series, April, 1978.

The above amount is examined to determine whether all or a portion will be included in the PCSC, based subjectively on hospital and HSA input, and in the financial analysis. To ensure that no double counting occurs, budgeted capital expenditures are compared to current year capital expenditures.

The financial analysis determines whether normal tolerances (generally a maximum of fourteen days cash-on-hand) have been met. Other analyses are done on various standard financial ratios (i.e., trends are examined over time). However, these analyses are specific to the hospital (not subject to peer group comparison), and there are no predetermined levels of acceptability.

5. Deductions from Revenue

Deductions from revenue (third-party contractual allowances, bad debts, and charity) are passed through to the payor to the extent that they meet screening requirements in a comparison with peer group expenses. They are also evaluated as trends over time, and bad debts as a percentage of total revenue are examined.

6. Analysis of Proposed Rates and Cross-Subsidization

After the primary, secondary, and other element screens, the hospital is subjected to a revenue-to-expense ratio analysis, which is undertaken to satisfy the statutory requirement that rates be reasonably related to costs. The current target is a five percent variance between expenses and revenues.[1]

7. Performance Analysis

This analysis examines the actual performance of the hospital over time, particularly in terms of rates and cross-subsidization, against what the Commission has approved. Current estimated rates and cross-subsidization are compared to Commission-approved rates and cross-subsidization for the current year. Historical trends in approved performances versus actual performances are also examined to determine if the hospital is moving in

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[1]While the Commission does have the authority to mandate compliance with this target amount and, in fact, disallows additional total revenue when generated through over-target cost/charge variances, it has not as yet developed a compliance methodology for the case where variances beyond the target do not affect total revenue (i.e., due to the cancellation of one department for another). The Commission does, however, bring variances beyond this target to the attention of the hospital during public hearings and presses for reductions in these variances to bring them in line with the five percent guideline. It will also grant exceptions where justified.

the correct direction. If the Commission finds that the hospital's actual performance is incongruent with its approved performance, it is cautioned about its pricing policies. These findings, along with recommendations, are presented in order to bring the hospital in concert with what the Commission has approved.

Negotiation

As mentioned earlier, hospitals are provided with the budget review results prior to the public hearing before the Commission. At this time, the hospital may review those areas that staff have recommended to be disallowed on the basis of their analyses and either prepare justification for inclusion of these exceptions or modify their requested rates to reflect the recommended disallowances. Any justifications are presented to the Commission at the public hearing.

Reimbursement and Differential Pricing

The Commission does not set a specific schedule of departmental prices for each hospital. Rather, they set an allowable rate per unit of service (e.g., RVU, EKG, treatment, patient day) in each revenue department, based on projected volume and allowable revenue for that department. By summing over all departments, the hospital is allowed to generate a certain level of revenue for its projected volume.

Once an allowable total rate-setting revenue (TRSR) is determined, the payment rates are calculated, depending on the hospital's reimbursement group: Type I, II, or III (the retrospective control group). When the Washington Commission received its HCFA contract as discussed earlier, hospitals from each peer group were randomly assigned to a payment type.[1]

Payment Type I. Under this portion of budget payment mechanism, hospitals submit their estimates of the distribution by quarter of their total rate-setting revenue needs. These needs (as approved by the Commission) are then allocated among payors based on historical utilization (RCC method) and differential payment. These amounts are further modified by the estimated copayments and deductibles of each payor, and by comparisons of estimated to actual copayments and deductibles from previous quarters. This quarterly allocated amount to the payors is then reimbursed during the year to the hospital in six semimonthly payments. At the end of the year, however, hospitals are subject to year-end compliance. For Type I payment, if the hospital's revenue is equal to or below that approved by the Commission, the hospital is considered in compliance. If the hospital's actual revenue is above the approved revenue, a fixed variable ratio is applied to the excess revenue resulting from increased volumes, and hospitals will only be allowed to keep the variable portion associated with charge-based payments.

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[1]A list of hospitals in each payment group is contained in Appendix C.

All other excess will be deducted from the next year's total allowable revenue.[1] This deduction, however, only applies to that portion of revenue related to the nonparticipating payors.

Payment Type II. Under this payment type, hospitals are reimbursed on a percentage of billed charges basis. The percentage of charges to be paid by each payor is determined on the basis of historical utilization (RCC) and the differential payment schedules. During the year, the payor and beneficiary then reimburse the hospital their percentages of charges as utilization occurs.

Type II hospitals, however, are also subject to year-end compliance. The difference is that, for Type II hospitals, both underages and overages on approved revenue are considered. Fixed variable ratios are again applied to the discrepancies in both directions. If the hospital has underprojected its volume (and revenue), it may keep the fixed portion of that revenue, and the variable proportion will be deducted from the following year's approved revenue. If the hospital has overprojected its volume, the hospital may keep the variable proportion of the revenue, and the fixed proportion will be deducted from the following year's approved revenue.

Payment Type III. While budget review is conducted for Type III hospitals and a total allowable revenue is set, payors reimburse based on their regular reimbursement methods, i.e., retrospective for Medicare, Medicaid, and so on. Type III hospitals, however, are subject to year-end compliance and adjustments are made to the following year's approved revenue. Since actual payments to hospitals are not controlled (other than through adjustments to a subsequently approved budget), the Commission does not actually control the amount of reimbursement; however, if a hospital sets charges that are inconsistent with the total approved revenue, technically the hospital has committed a misdemeanor and can be prosecuted. To date, this has not occurred.

Differential Pricing. The differential pricing mechanism used in the calculation of payment attempts to equitably allocate certain costs incurred by the hospital for a particular payor to that payor only. It is also used to cover elements of cost that are not paid for by Medicaid and Medicare. The differential pricing mechanism covers the areas of billing costs, nursing differentials, special reporting, medical review, credit and collection, time value of cash (cash flow), expenses with no federal participation, and payment lags.

First, an initial distribution of total allowable revenue is made to the various payors, based on their historical proportion of total utilization.[2]

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[1]A more detailed discussion of year-end compliance criteria is presented in the process section.

[2]The ratio of charges to charges (RCC) method is used.

Following this initial distribution, the distribution is modified successively to reflect certain differentials in elements of cost. These include:

Billing - Costs associated with billing are distributed among payors based on the percentage of time devoted to the arious payors.

Nursing - Medicare will pay 8-1/2 percent additional nursing costs relative to other payors for its routine patient days.

Special Reporting - Costs related to the maintenance of ongoing statistics for third-party reporting and the costs associated with filing cost reports will be distributed among payors according to the number of admissions by payor type.

Medical Review - Costs related to PSRO are allocated to Medicare. Other medical review costs are allocated among Blue Cross, Labor and Industries, and the Other Payor categories, based on the adjusted RCC.

Credit and Collection - Credit and collection costs are distributed among payors in accordance with an estimate of each payor's bad debt experiences.

Time Value - The initial distribution is based on days outstanding by payor type.

No Federal Participation - Medicare and Medicaid will not participate in certain costs (primarily return on investment to proprietary hospitals) beyond existing federal guidelines. This cost is allocated to all payors, except Medicare and Medicaid, on an adjusted RCC basis.

The above costs are distributed among the various payors and the total allowable revenue is then finally apportioned to each payor.

With Type I payment, each payor pays its semimonthly portion of revenue to the hospital. With Type II payment, the total amount of charges needed to generate total allowable revenue is calculated. Each payor then pays a certain percentage of charges to reflect the final distribution of total allowable revenues from each payor.

Year-End Compliance

Within the Commission's statutory authority is the charge to assure the public that the rates of the hospitals have been appropriately implemented, either prior to the beginning of the hospital's fiscal year or as amended during the fiscal year, to cover its total financial needs, and that no excessive charges or excess revenues have been realized.

Early on, the Commission recognized that volume projection is not an exact science and that there are many factors that may cause actual volumes to vary from projected volumes. In addition, the Commission realized that there were other factors, such as changes in case mix and intensity, physical plant, economy of the service area, population changes, and other similar factors, that could influence hospital operations during the budget year. Accordingly, the Commission will allow a hospital to submit requests for amendments to the initially approved revenues and rates; however, even this process will not ensure that the hospital can perform precisely as projected at the time of the budget or budget amendment. Therefore, the Commission has adopted a degree of flexibility in evaluating the hospital's year-end compliance, and has agreed that an aggregate measure of performance is preferable for several reasons. First, the Commission desired to retain as much management discretion within the individual hospital as possible. Second, the Commission expressed the desire that hospitals benefit from cost containment efforts that might result in additional revenue beyond their actual financial requirements. Third, it was recognized that each hospital would have to develop an internal monitoring mechanism in order to avoid a noncompliance situation, which would result in an unexpected fiscal impact in a subsequent period.[1] Therefore, the Commission agreed that year-end compliance should be first measured by the actual aggregate average rate per adjusted patient day as compared to the aggregate average rate per adjusted patient day as approved during the budget and rate review process.

It was further concluded that hospitals should have an opportunity to explain and justify variances from the approved rates and revenues and that any evidence of noncompliance initially would not be considered as an intentional violation; any revenue adjustments deemed appropriate by the Commission would be applied against the hospital's next full fiscal year financial requirements. Finally, it was determined that greater flexibility should be applied to compliance criteria in the first year of regulation than in subsequent years.[2] Accordingly, the Commission has adopted several policies over time--first to distinguish the early budget review process from the HCFA reimbursement demonstration project, and second to be more flexible in the first year.

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[1]Memo to Hospital Administration from Frank Baker, Executive Director, Washington State Hospital Commission, October 30, 1978.

[2]Ibid.

For calendar year 1976, hospitals were allowed volume variances within specific corridors, depending on peer group. Actual revenue was compared to approved revenue adjusted for the volume changes and then compared to the allowed revenue range. If actual revenue exceeded the upper limit of the corridor, a departmental analysis was carried out. The hospitals then had the option of submitting reasonable, logical, and supportive justification for the variance. The corridor for Peer Groups 1, 2, and specialty hospitals with fewer than 50 beds was ±3 percent; the corridor for Peer Groups 3, 4, 5, and specialty hospitals with 50 or more beds was ±1.5 percent.

In the second calendar year (1977) this policy was changed. First, the corridors were dropped. Second, the hospital could submit fixed variable cost ratios or marginal cost by department, subject to Commission approval, for use in estimating compliance amounts. However, the hospital still had and continues to have the option of providing reasonable, justifying information.

This policy was further refined and supplemented in the third calendar year (1978), when specific fixed variable ratios were set for each peer group. They were:

Group	Fixed Variable Ratio
Peer Groups 1 and 2 and specialty hospitals with fewer than 50 beds	80/20
Peer Groups 3 and 4 and specialty hospitals with more than 50 beds	70/30
Peer Group 5 hospitals	60/40

Again, fixed variable ratios submitted by hospitals were still evaluated individually on their merits. Few hospitals, however, attempted this complex determination. Type I hospitals were subject to these criteria only when actual revenue exceeded approved revenue, and compliance amounts were related only to those payors not participating in the experiment.

The Appeals Process

If a hospital is dissatisfied with its approved budget, it may request reconsideration and present additional information in an informal hearing, request an amendment to its approved budget during the year, or petition for a formal hearing. All problems in the past have been handled either through rate amendments or informal hearings. Most of the issues have involved capital needs in excess of depreciation prior to Certificate of Need approval, salary and wage settlements from collective bargaining agreements, and

unanticipated increases in certain cost categories, such as fringe benefits and state industrial insurance.

In terms of formal proceedings, the Commission is bound by the state Administrative Practices Act; however, when a hospital requests a formal hearing, the Commission may, upon consideration of the facts, reject the hospital's petition. If the Commission rejects the petition, the hospital must go through the judicial process for satisfaction. If the Commission honors the petition for a formal hearing, the hearing date must be set and notification given at least twenty days prior to the date, unless an emergency warrants otherwise, with agreement by all parties. The notice states the issues, the statutory authority of the Commission, and a short statement of the matters asserted. A hearing officer is appointed[1] and all issues are transcribed. All parties may cross examine at the hearing and issue subpoenas. Burden of proof lies with the hospital. The hearing officer must decide on the basis of facts presented as evidence whether the Commission has been unreasonable, arbitrary, or capricious in its actions. If the hearing officer decides against the hospital, the hospital may appeal to the court where the decision is based on whether the Commission has exceeded its authority. The court process is one of a limited judicial review rather than a new trial.

To date, there have been two requests for a formal hearing; however, both were withdrawn in favor of an informal hearing procedure. The first request involved additional funding requirements for which a purpose had not been identified. The hospital subsequently presented the additional data and was granted its request. The second request involved the amount of allowable revenue for a certain expense category, and some portion of the revenue request was subsequently granted.

To date, only one suit has been filed. It was, however, withdrawn when the Commission agreed to reconsider the budget in an informal hearing. The hospital submitted additional data and was granted most of the disputed revenue.

Program Cost

Data on program expenditures for the Washington system are available for 1975 through 1977, with estimates for 1978 and 1979. These data are aggregated and listed in Table 4 by year, in total and on a per-hospital basis.

Funds for rate setting come from three major sources: the HCFA contract, assessments to hospitals (based on 0.04 percent of hospitals' gross operating expenses), and state general fund appropriations. Table 4 indicates that

[1]Generally, an administrative law judge who would be employed by the Commission to hear the proceeding.

TABLE 4: Program Expenditures By Hospital By Year, 1975 to 1980

Year	Administrative Expenses	Rate-Setting Expenses	Total Expenses	Total Expenses Per Hospital
1975	$221,890	- 0 -	$ 221,890	$ 2,055[a]
1976	463,870	$238,999	702,869	6,390
1977	573,286	277,317	850,603	7,733[c]
1978[b]	760,648	386,182	1,146,830	10,426[c]
1979[b]	785,610	417,498	1,203,108	10,937[c]
1980[b]	588,594	101,052	689,646	6,270

[a]This per-hospital figure is somewhat misleading, since budgets were reviewed with fiscal years beginning on or after October 1975. The dollar figures, therefore, represent more developmental than rate-setting effort.

[b]These data were unavailable for nonfederal short-term acute hospitals for these years. The number of hospitals in 1977 was therefore used. Also, the expenditures are estimated, rather than actual, amounts.

[c]For these three years, approximately 52 percent of the budget was supported through the HCFA contract. The unit hospital cost for these years, therefore, is inflated with developmental dollars.

rate-setting expenditures per hospital increased from $2055 in 1975 to an estimated $6270 in 1980. This represents an overall increase of approximately 200 percent over the five-year period, or approximately 41 percent per year. Using these rough figures, the program would have to save $690,000 of expenditures in 1980 to be cost effective. The reader should note, however, that these years represent early as well as continuing development activities (such as research on appropriate fixed variable ratios), supported by the HCFA contract. In fact, the estimated $6270 per hospital in 1980 (the last year of the HCFA contract) shows a decrease of 43 percent from the previous year's estimate.

INTERACTIONS

Upon analysis, the overall impression of the Washington state system is one of a lack of conflict and confrontation and an existing spirit of cooperation. This is further borne out by the absence of legal challenges to the system and multi-payor participation. There is evidence, however, that as the system has become more rigorous, the Commission, the hospitals, and the planning community may be approaching a crossroads. Furthermore, Medicaid has only begun to realize the full financial impact of the system.

The following section examines the interactions among five key participants in the Washington state rate-setting process. The Washington State Hospital Association is the most active and vocal participant, but has exerted limited influence on the rate-setting system since its inception; its influence in the legislative development was, however, extensive. Medicaid and Blue Cross have been willing participants in the PR experiment. The Rate-Setting Commission has a close linkage with the state health planning office, in that the Commission performs the financial analysis for Certificate of Need applications. The SHPDA is currently involved in the development of a state health plan. Work in the area of standards and guidelines is also in very preliminary stages. The Washington State Hospital Commission has also established linkages with the planning community. Several HSAs work with the Commission in the area of volume projections. Labor (hospital-based) involvement in rate setting has been minimal, if not nonexistent.

The Washington State Hospital Association

Overview

There is extensive interaction, both formally and informally, between the WSHA and the Commission. WSHA members have participated in the rate-setting process through various ad hoc committees established by the Commission. There have been few controversies surrounding rate setting in Washington state that have served to mobilize the membership. Perhaps of greatest overall concern has been the uncertainty surrounding the Medicare

cost cap. It appears, however, that the rather dominant and forceful leadership of the Rate-Setting Commission has diminished the role of the WSHA.

Interactions

The WSHA decided seven years ago to "accept reasonable regulation at the state level as an alternative to federal controls." The Association describes this action as "a calculated gamble."[1] The Hospital Association, once realizing that some type of legislation was inevitable, decided to become actively involved in the development of the legislation and regulations. The Association contended that the essential elements proposed by the WSHA came through the legislative process unscathed, which explains to some degree the cooperative relationship to date between the Commission and the WSHA.

Key points that the Hospital Association considered vital to the legislation included: an independent commission, not part of the state bureaucracy; a requirement that one commissioner have expertise in hospital administration; and recognition of individual hospital financial needs rather than requirement of a flat payment.

The Commission's enabling statute does not specifically require formal interaction between the WSHA and the Commission. That is, the Commission is not mandated to consult with the WSHA on matters of policy and on the rules and regulations it proposes. The statute does require that a technical advisory committee be appointed by the Governor and include hospital representatives. Further, and perhaps most important, one commissioner must be representative of the hospital industry. Hospital administrators actively involved with the Commission have tended to be those that are active members of WSHA.

In addition to serving on the Commission's Technical Advisory Committee and several ad hoc committees, the WSHA has established a Prospective Reimbursement Committee. Furthermore, the Washington chapter of the Hospital Financial Management Association has been actively involved in monitoring the activities of the Washington State Commission. Both groups have developed position papers and conducted analyses of various aspects of the Washington system, e.g., compliance procedures and uniform reporting. The WSHA Prospective Reimbursement Committee has conducted periodic surveys to determine the hospital association's membership views on Commission decisions and will also be responsible for the hospital association's evaluation of the Prospective Reimbursement Project (PRP).

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[1]Washington State Hospital Association, The Turning Point, Annual Report, 1977-1978.

It would appear that the WSHA has begun to reevaluate the relationship it has established with the Commission, a decision most likely prompted by internal dissension within the Association over the Prospective Reimbursement experiment. Many within the Association felt that the PRP was too much to impose on hospitals so soon after requiring them to make major changes in existing accounting and budgeting practices. Most importantly, however, the PRP left many questions unanswered, which created numerous information gaps. Of key concern has been the waiver from HCFA on the growth and development issue. The delay in receiving this waiver caused the Association to exert some pressure on the Commission to cancel the entire project. More importantly, the confusion over this issue has somewhat damaged the credibility of the Commission and distorted the objectives of the experiment.

Resources Devoted to Rate-Setting Activities. The WSHA maintains a staff of sixteen. Of these, one person is assigned half time to keep abreast of rate-setting activities. With the implementation of the PRP, the Association upgraded the requirement for this position from that of an accountant to a CPA with hospital experience.

State Health Planning and Development Agency

Overview

The Department of Social and Health Services is the designated state health planning and development agency for the State of Washington. Not designated until July of 1977, the SHPDA finds itself in the position of coming from behind; while HSAs are busily completing health systems plans for their respective regions, the SHPDA is still in the process of designing a state health plan.

In addition to developing the state health plan, the SHPDA is also responsible for the Certificate of Need program, as well as for regulating health facilities and staffing the cooperative health statistics program. The Rate-Setting Commission, in accordance with state regulations, performs the financial feasibility studies on all CON applications and submits an analysis and recommendation to the SHPDA. The Director of the state health planning and development agency is also a member of the Commission's Technical Advisory Committee. However, the relationship between the Commission and SHPDA revolves around the CON program review. Thus far, the SHPDA has had a limited impact on rate setting in Washington. Without a state health plan, the SHPDA is virtually unable to actively influence the activities of the Rate-Setting Commission.

Interactions

The Commission has been conducting financial analysis for the CON program for four years. More than 200 applications have been completed

by the Commission, of which only a few have not been accepted by the CON program. The process is illustrated in Figure 6. In reviewing CON applications, the Commission answers the following questions:[1]

- Is the projected cost per unit of service reasonable?
- Will the project result in an unreasonable increase in patient charge structure?
- Is the project cost effective as compared to alternative methods of design and construction available?
- Does the project make use of available resources without unnecessarily duplicating existing facilities and services?
- Has thorough consideration been given to the economics and improvement of services that could be derived from joint, cooperative, or shared services or resources from facilities?

It is evident that in answering these questions the Commission must go beyond a mere financial analysis and deal with some planning issues. In fact, the Commission has been accused by hospitals of overstepping its authority in reviewing not only cost containment and financial feasibility, but needs and staffing as well; the latter two areas are considered the province of the HSA. In fact, the Commission's analysis does contain a discussion of needs and staffing, reflecting its belief that financial feasibility and cost containment cannot be analyzed without consideration of these issues.[2]

Another aspect of this arrangement between the Commission and the SHPDA is that the review process is structured in such a way that a yes or no decision must be made. If the Commission does not approve, this is considered the same as no recommendation at all. Should an HSA recommend approval, the state then finds itself in an awkward position, since it does not have a definitive state health plan based on specific standards and criteria.

The SHPDA is optimistic, however, that a mechanism to provide firm linkages among HSAs, the Commission, and the SHPDA is forthcoming. In a report prepared for the Commission by an outside consulting group, it was

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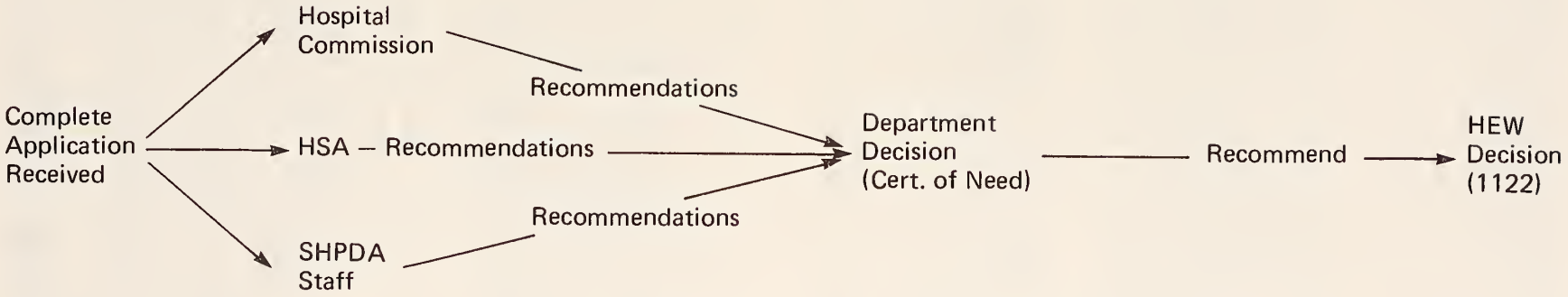
[1]J.A. Beard, "The Link Between Planning Decisions and Cost Control," Paper presented to 17th National Meeting of Public Health Conference on Records and Statistics, June 7, 1978.

[2]Ibid.

Figure 6
SIMPLIFIED FLOW CHART OF CERTIFICATE OF NEED/SECTION 1122
REVIEW PROCESS FOR HOSPITAL CONSTRUCTION



recommended that the Commission approve only those hospital capital expenditures that had been determined as necessary through documentation in a health systems plan.

Health Systems Agencies

Overview

There are four health systems agencies in Washington. Lack of time and resources prohibits most HSAs from becoming extensively involved in Rate-Setting Commission activities. Historically, interaction has been limited to the review and comment that HSAs perform on Certificate of Need applications. More recently, the Commission, in an effort to exercise control over projections of volume by hospitals, asked HSAs to review and comment on hospital volume projections.

As HSAs have become more sophisticated and begun completing their health systems plans, they have begun to voice their concerns over the respective roles of the HSAs and the Commission. Although HSAs have become more vocal, until a state health plan is developed and further work completed in the area of standards and criteria, their influence will be outweighed by the strength and sophistication of the Commission. This is not necessarily a drawback, since the Commission is fulfilling a role that the HSAs are not yet able to fill.

Interactions

Of the four HSAs in Washington, only one has enough staff to devote to the effort of compiling volume projections for hospitals within its area. The Puget Sound Health Systems Agency has assigned a staff person half time to monitor the Commission's activities and compile historical data for trend analyses, population forecasts, and volume projections. For the most part, the other HSAs can only review volume projections on a hospital that appears to be completely out of line.

The process used by the Puget Sound Health Systems Agency is beneficial to both the Commission and the hospitals. Using Hospital Utilization Reports submitted to the state, the staff compiled total admissions and patient days for each hospital in the HSA for calendar years 1973 through 1977. These data were then analyzed to derive a measure of seasonal variation for estimating annual volume. Regional analyses are planned for next year. A draft of the historical analysis and projections is sent to each hospital ninety days prior to the end of its fiscal year.[1] Hospitals have a month to respond to the HSA, indicating whether they agree or disagree with the projections and the reasons for their response.

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[1]Prospective hospital budgets are due at the Hospital Commission sixty days prior to the end of the current fiscal year.

When the Hospital Commission receives a complete budget submittal, it mails the volume analysis worksheet to the HSA. Staff then send the Commission their comments on the hospital's projected admissions and patient days. The data submitted by the HSA set the floor for the volume projections; the hospital must justify anything over this floor to the Commission. This arrangement has received a mixed reaction from hospitals, ranging from antagonism to cooperation. HSA staff consider it to be to the hospital's advantage to interact with the HSA on its volume projections.

There are a number of areas in which HSAs and the Commission have clashed, including the role of the HSA. The Commission has publicly stated that hospitals must fund planning studies or go to HSAs for the funding. The HSAs, on the other hand, contend that funds for planning should come out of the Planned Capital Service Component of the hospital's budget. The role of the HSA is not to do individual, institutional planning; rather, its role is to oversee and evaluate the results. There are a number of issues on which the Commission and the HSAs eventually must become reconciled. As the Commission's methodologies become more rigorous and the HSAs increasingly sophisticated, their respective roles will have to be clearly defined.

Third-Party Payors

Overview

Both Medicaid and Blue Cross agreed to be participants in the prospective reimbursement experiment. Blue Cross participated because it felt it should be involved in major industry issues, and because it viewed some type of prospective reimbursement as inevitable within five years. Medicaid considered the proposal a comprehensive one and viewed it as a mechanism to cut costs. Blue Shield is considered the only significant payor not participating. Blue Shield writes between eight and ten percent of the insurance coverage in the state, and commercial insurance companies represent less than ten percent of the state's total patient days. Initially interested in participating, this group could not arrive at a unanimous decision on how to reimburse hospitals.

Blue Cross

Blue Cross, having followed the legislative developments of the Rate-Setting Commission, first became involved when the Commission began to consider prospective reimbursement. The President of Blue Cross participated in a committee that developed a prospective reimbursement plan that was originally implemented on a voluntary basis. Blue Cross also contributed a part-time staff position during the Commission's early years. Currently Blue Cross maintains an ongoing relationship with the Commission through its participation on ad hoc committees. The Vice Presidents of Finance and Provider Relations monitor both the ongoing financial and political aspects of prospective rate setting in the state. Approximately 1 to 1.5 FTEs may be attributed to keeping abreast of prospective reimbursement activities.

Blue Cross has not seen any evidence of changes in hospital cost containment behavior, but it has seen evidence of some budget gamesmanship. This view is shared by the Washington State Hospital Association.

Medicaid

As in the case of Blue Cross, Medicaid is also closely tied into the activities of the Rate-Setting Commission. Its primary mechanism for interaction is through ad hoc committees. While the relationship between Medicaid and the Commission can only be described as cooperative and enthusiastic, this is one interaction that is sensitive to the state Medicaid budget constraints.

The future holds the potential for a conflict of priorities between these two agencies. The key question focuses on a definition of the primary goal of the PRP experiment: to contain costs, or to realize equitable cost distribution among payors. While it cannot be said that Medicaid is against uniform payor participation, the question demands consideration of its cost. Medicaid has already begun to notice an upward trend. Although the PRP experiment may not be solely responsible, Medicaid is finding itself paying out more than it had previously. Given that Medicaid is now paying a portion of bad debts and may also be sharing in capital costs, it is altogether conceivable that in the short run costs will rise. Medicaid staff are currently investigating the magnitude of cost increases associated with the PRP and have approached the legislature for an increase in its appropriation.

RIGOR, INCENTIVES AND EQUITY

Rigor

The rigor of hospital rate review by the Washington State Hospital Commission will be assessed along the following three dimensions: structure, process, and outcome. First of all, with respect to structure, it is certainly relevant that the Commission is organized as an independent commission. Although the Commissioners are appointed by the Governor, there is no indication that political strategy plays a role in their selection. Of course, this could change in time, as governors change and as hospitals begin to reassess their early commitment and support of the Commission. In any event, the Commission is independent of political concerns in the short run, except as it must negotiate the conditions of Medicaid participation.

However, the formal structure is perhaps less important than the informal one. Because of the broad support, general acquiescence, and widespread confidence that the Commission has enjoyed to date, it has not had to expend much of its energies and resources on justifying its action or defending itself against legal challenges. More so than in other states,

it has been able to focus its attention on actual review and developmental work for that purpose. Moreover, the budget of the Commission has been substantially augmented in recent years by experimental funds from the HCFA contract, although staff resources are extremely strained at times due to seasonality of the review process, and the present level of staffing seems somewhat inadequate.

The Commission reviews annual budget requests from all hospitals and determines total allowable revenue, contingent on volume. Hospital compliance is mandatory and it is a misdemeanor for hospitals to not set charges in line with the approved revenue. As of 1978, payment rates were set for Blue Cross, Labor and Industries (Workman's Compensation), and Medicare and Medicaid, making Washington one of the few states to include both federal payors.

The supporting legislation requires that the Commission approve reasonable rates that will provide sufficient revenue to maintain the solvency of nonprofit hospitals. That is, the Commission can make hospitals more efficient but it cannot close them down. Such a restriction no doubt limits the cost-savings potential.

In general, health planning in Washington is still in its formative stages and has little interaction with the Commission. However, the Seattle HSA prepares hospital volume forecasts for use by the Commission. The state does not yet have a Certificate of Need (CON) law, and the Commission's relationship to the existing CON program is substantial. As in the Section 1122 program, the Commission conducts the financial feasibility analyses for the application.

Finally, the importance of the personalities involved cannot be ignored. The Commission has a "strong" Executive Director and key staff with the requisite skills and abilities to effectively administer the complex review process. It is also germane that the Chairman of the Commission is a formerly prominent CPA, now retired, and thus has the financial expertise needed to interact effectively with staff and guide the Commission in its review of staff recommendations. Furthermore, the Commission Chairman works at Commission business virtually full time, even though the position is voluntary and unsalaried.

The rigor of the review process itself warrants review as well. To begin, Washington has adopted uniform reporting, and it is doubtful that any budget review system could be very rigorous without such a mechanism for obtaining comparable information from all hospitals. The review itself is strategic, using 70th percentile peer group norms in screening for high cost

areas and then reviewing problem areas in detail.[1] In general, revenue requests in excess of the 70th percentile on detailed screens are disallowed initially by staff. The detailed screens are extensive, and both the screening and peer grouping methodologies can be said to be state of the art, except that case mix is not explicitly considered. However, it is noteworthy that Washington, unlike other states, relies almost entirely upon the screens and interhospital comparisons in reviewing requested increases in revenue due to price; for example, projected price increases are not also evaluated by trend analysis. Thus, if hospitals systematically over- or underestimate the applicable rates of inflation, these increases (or decreases) would most likely be reflected in the approved revenues.

Since total allowable revenue is set contingent on a particular volume forecast and the approved volume level is used as a "yardstick" for gauging compliance, it is important to have a rigorous review of volume forecasts as well. The volume analysis is also strategic, potentially involving a variety of trend analyses plus consultation with the HSA. The review process is careful and comprehensive. However, the state of the art in this area has not progressed very far.[2]

Prior to informal hearing on the budget request, hospital representatives typically meet with staff to review areas of the budget that might need further elaboration. It is apparent that staff recommendations do change as a result of these meetings. However, the reasons for changing recommendations are not necessarily a matter of public record, and inasmuch as an opportunity to observe this process has not arisen, final judgment for the time being has been reserved. Nevertheless, the burden of proof appears to rest with the hospitals at all times. More subjective (non-mechanistic) considerations apparently also enter into preparation of the initial staff recommendation. For example, the staff work-up on one hospital whose past revenue was high in relation to volume and whose volume projections were unrealistic was examined. The hospital was merely asked to accept the revenue reductions consistent with a substantially reduced level of volume. It was felt that the hospital would have a difficult enough time making this adjustment and that it should not be further penalized in that year. All things considered, the review process cannot be seriously faulted; it combines state of the art methodology with attention to "materiality," i.e., whether or not the benefits justify the costs, and with a greater chance of equity permitted by some reliance on subjective judgment. A system could be said to be more rigorous without these latter two, but that would not necessarily make it a better system.

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[1]The peer group norm had been earlier set at the 50th percentile, but it was found that the cost-savings potential in the 50th to 70th percentile range was comparatively small in relation to the resources expended in review.

[2]No attention is given to length of stay. The average length of stay in Washington is low vis-a-vis national norms, and as such, excess utilization is not perceived to be a problem.

The Commission usually accepts staff recommendations. However, there are exceptions and these tend to be mostly idiosyncratic, or not related to differences in policy between the Commissioners and staff. However, there is one exception: the Commission will accept any wage settlement that emerges from collective bargaining. Perhaps this is done in deference to the labor presence on the Commission. In any event, there is no attempt by the Commission to exercise restraint on the rate of increase in union-negotiated wages. The degree of interdepartmental cross-subsidization is also reviewed by staff and addressed in the hearing. The present target is to have cost and revenue for all departments within a five percent corridor. Although there is considerable debate on this point, it has not been formally required of hospitals because of uncertainty about the Commission's authority to enforce it. The Commission would like to see the law revised to incorporate explicit authority for this purpose.

The definition of financial requirements in Washington includes a "planned services and capital" component. In addition to standard working capital requirements, this capital component includes funds for planning and for capital needs in excess of funded depreciation for approved projects. Whereas this may have a cost-increasing effect in the short run inasmuch as it expands financial requirements, it is thought to have a net cost-decreasing effect over time. The amount of the capital advance is determined consistent with analysis of optimal financing, i.e., an assessment of the equity-to-debt ratio that minimizes total system cost. Most outreach or community-oriented activities, including preventive medicine programs, social services, and family planning, are not allowed as financial requirements, but teaching costs are allowed. Other items allowed in the financial requirements are fairly standard.

The Commission systematically monitors year-end compliance using fixed variable cost ratios to adjust for volume changes. Hospitals have the option of defining their own marginal cost items, either in the aggregate or by department, subject to Commission approval. Alternatively, a fixed percentage guideline established by the Commission for each peer group is applied. Financial requirements in the budget year are reduced by the amount of actual past-year revenue in excess of the volume-adjusted budget figure. Likewise, the financial requirements would be increased by the amount of any shortfall. The application of the marginal cost factor is now being reviewed only during the informal hearing as part of the hospital's review for its next fiscal year, not through staff revisions of their initial recommendation.

It is not possible at this time to assess program rigor from the outcomes. However, data on rates of change in the approved rate should soon become available.

Incentives

The various intended and unintended incentives to behavioral change found in the Washington system deserve consideration. Consider first the three different reimbursement schemes under the experiment:

- Type I--portion of budget payment and no final settlement (except for non-participating payors),
- Type II--payment by percentage of charges, but final settlement for the volume-adjusted approved revenue,
- Type III--retrospective payments, but final settlement for the volume-adjusted, approved revenues.

The incentives presented by these reimbursement types are complex. In particular, the units of payment are different from the unit of final settlement. In consequence, the short- and long-run incentives are different.

Type III reimbursement is the same as it had been prior to the experiment. Under this cost reimbursement scheme, the annual amount of total allowable revenue is determined, contingent upon certain approved volume projections. These revenue and volume levels also imply an aggregate average rate per adjusted patient day. However, if the actual volume deviates from the projected volume, the amount of allowable revenue is adjusted by application of a fixed variable cost ratio to the approved rate. If the variable cost factor being used fairly approximates the "true" incremental costs, this procedure removes the usual incentive within *per diem* reimbursement to expand patient-day utilization. Of course, even if the adjustment is incomplete--as it might well be--the incentive to expand utilization is less than it would have been without any adjustment at all.[1] This volume adjustment procedure further introduces an incentive for "gaming" behavior into the budget review process. In the long run, it gives hospitals an incentive to overproject volume inasmuch as a higher average final rate and greater total revenue would be allowed than if the same initial rate had been approved for the volume actually achieved. For example, suppose that a hospital's approved rate is going to be $100 per day and that its real volume expectation is 10,000 patient days; however, the rate is approved for 12,000 patient days instead of 10,000. Taking the variable cost for this hospital to be $40 per day, the volume-adjusted, approved revenue level is not $1,000,000--equal

[1]The determination of fixed variable cost ratios is not an exact science and there is probably a tendency to be somewhat generous so that hospitals are not penalized.

to $100 per day x 10,000 patient days--but rather $1,200,000--equal to $100 per day x 12,000 patient days minus $40 per day x 2,000 patient days. This figure gives a final average rate of $120 per day. On the other hand, if a hospital's marginal costs are low in relation to its volume, it would have an incentive to underproject volume and thereby obtain a higher rate.

Although actual costs are still reimbursed retrospectively under Type III, financial requirements for the subsequent year are augmented or reduced by the amount of any variance from the approved revenue level. While a hospital could conceivably "snowball" such adjustments to financial requirements for a period of years, with actual revenue exceeding the approved amount by successively larger amounts, the hospital can be criminally prosecuted for doing so. There is no present evidence that such behavior exists. Consequently, the reimbursement is more nearly prospective than retrospective, and such reimbursement cannot be used as an intrastate control for the more experimental types of reimbursement systems. Retrospective payments in excess of approved revenue essentially become cash advances against future financial requirements. Of course, this critically depends upon effective enforcement of year-end compliance. In any event, the usual retrospective payment incentives remain in the short run and it is difficult to determine whether hospitals are responding to these shorter-run incentives or to the longer-run incentives associated with final settlement, as noted above.

Under Type I reimbursement, hospitals receive the approved revenue amount allowed to participating payors. There is no retrospective volume adjustment. The incentive to overproject volume is thus even stronger than for Type III reimbursement. Also, there is no confusion about the incentives in this case. There is also, as least in the short run, a substantial incentive to reduce utilization through shorter stays and fewer admissions. However, if patients were merely shifted to other non-Type I hospitals, an apparent savings from Type I reimbursement could actually mean a greater cost of hospital care. Of course, such a behavioral dynamic could not continue indefinitely because a hospital's approved volume projections would be reduced accordingly in subsequent years, and unit costs would rise to a point resulting in further disallowances, which ultimately would threaten the viability of the hospital. The duration of the present experiment is probably too short for such longer-term incentives to begin influencing behavior. Finally, whereas a hospital's revenue is not adjusted for a shortfall in volume, the Commission will support budget amendments if volumes over budget can be justified as arising from circumstances beyond the control or anticipation of the hospital. That is, the risk is not symmetrical. This policy could be cost-increasing, inasmuch as reimbursement becomes more nearly cost related if hospitals are losing money due to volume change, but remains prospective if reimbursement exceeds cost for the same reason. If the Commission were similarly receptive to other budget

amendments from Type I hospitals, the merit of the entire reimbursement scheme would be under question.

Type II hospitals are paid a percentage of charges as determined by the price differentials. However, year-end compliance is administered in the same fashion as for Type III, including the volume adjustment. Nevertheless, Type II reimbursement is more generous than Type III, which pays only the lesser of cost or charges. According to the terms of compliance, Type II hospitals can retain revenue in excess of cost as long as the total approved revenue amount is not exceeded. Type II thus gives greater incentive to cost containment and therefore to rate reductions in subsequent years. The longer-run incentives toward volume projection are the same as for Type III hospitals. However, Type II entails an additional short-run incentive to understate volume. To the extent that actual volume in a Type II hospital exceeds the Commission-approved level, actual revenue will exceed the amount approved. Of course, the largest part of the added revenue will be taken away during compliance review.

The evaluation of these different reimbursement types in Washington is confounded by several extraordinary circumstances. First, the Medicare-Medicaid waiver was not obtained until a year or more into the experiment. During this interval, considerable uncertainty prevailed about the future; and it is not now possible to delineate the incentives as they were perceived to be. Second, and also important, the waiver agreement incorporates a statewide cost cap as discussed in the section on adoption, and all Type I and Type II hospitals in the state are collectively at risk for any cost increase in excess of the cap. If the cap ever threatens to become a binding constraint, the incentives toward cost containment associated with the cap itself will no doubt overwhelm the cost containment incentives associated with the experimental reimbursement schemes. Even so, it could have some effect toward strengthening the Commission inasmuch as all hospitals now have a vested interest in containing the costs of other hospitals.

The definition of financial requirements can also entail important incentives. In particular, the planned service and capital component allowance probably gives greater incentive to capital planning and capital investment than had existed formerly, since it is easier to obtain funds for these purposes. If so, it will be especially important to have strong HSA's and a strong CON program that can resist the more vigorous capital pressures. Many hospitals do not yet seem to understand the review process, which is very much a factor in the present environment. The system has evolved rapidly in the past few years and continues to change. For example, the Commission has had several different policies for evaluating and enforcing compliance. At present, there is still much uncertainty on the interdepartmental cross-subsidization issue and whether or not the Commission has authority to compel its elimination.

Equity

The equity or "fairness" of the Washington system merits consideration. First of all, payor equity is a conspicuous strong point. Under the waiver, all participating payors, including Medicare and Medicaid, reimburse on the same basis, except for demonstrated payor-related cost differences. In particular, Medicare and Medicaid are paying what has come to be regarded as being their "fair share" of hospital sector costs. This necessarily entails some redistribution of income among the Medicare and Medicaid programs and commercial, self-pay, and (to some extent) Blue Cross patients. That is, Medicare and Medicaid reimbursement is necessarily greater than it would have been otherwise, but this increase is fully offset by the reduction in payments from other sources. However, there are additional relevant dimensions of equity. For one, all hospitals are required to satisfy the same extensive reporting requirements, which are relatively more burdensome to small hospitals. Furthermore, it was said repeatedly that the system had much to do with driving "incompetent" hospital administrators out of the state because of their inability to satisfy the Commission. This may be true; but it may also be true that the Commission is applying an absolute standard to all hospitals that is not appropriate to smaller hospitals, thus compelling them to obtain financial expertise that has little operational value to them.

The nominal due process guarantees appear to be adequate. However, the likelihood of uniformity of review by a part-time, voluntary (unpaid) commission facilitates reasonable concern. This will be monitored in the future.

Finally, the peer groupings are a cornerstone of the review process in Washington. However substantial the groupings may be, all hospitals within a group may not be sufficiently homogenous and cannot necessarily be treated as equals. However, the problem is a generic one. A methodology is needed to adjust for relevant differences (case mix) within peer groups, an expected outcome of the research portion of the HCFA contract.

APPENDIX A

Hospital Health Care Services: Hospital Commission

Chapter 70.39
HOSPITAL HEALTH CARE SERVICES——HOSPITAL COMMISSION

Sections

70.39.010 Purpose.
70.39.020 Definitions.
70.39.030 Hospital commission——Created——Membership.
70.39.040 Hospital commission——Terms——Vacancies.
70.39.050 Hospital commission——Officers——Meetings——Compensation.
70.39.060 Hospital commission——Director——Secretary——Staff——Services.
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70.39.100 Uniform system of hospital accounting and reporting.
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70.39.120 Hospital costs and finances——Analyses and studies——Reports.
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70.39.150 Powers and duties of commission.
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70.39.180 Rules and regulations——Public hearings——Investigations——Subpoena power.
70.39.190 Review.
70.39.200 Penalties for violations.
70.39.900 Severability——1973 1st ex.s. c 5.
70.39.910 Liberal construction——1973 1st ex.s. c 5.

70.39.010 Purpose. The primary purpose of this chapter is to promote the economic delivery of high quality and effective hospital health care services to the people by establishing a hospital commission with authority over financial disclosure and budget and prospective rate review and other related matters, which will assure all purchasers of hospital health care services that total hospital costs are reasonably related to total services, that hospital rates are reasonably related to aggregate costs, and that such rates are set equitably among all purchasers of these services without undue discrimination.

The legislature finds and declares that rising hospital costs are a vital concern to the people of this state because of the danger which is posed that hospital and health care services are fast becoming out of the economic reach of the majority of our population. It is further declared that health care is a right of the people and one of the primary purposes for which governments are established, and it is, therefore, essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs. It is the legislative intent, in pursuance of this declared public policy, to provide for uniform measures on a state-wide basis to control hospital costs without the sacrifice of quality of service. [1973 1st ex.s. c 5 § 2.]

70.39.020 Definitions. As used in this chapter:

(1) "Commission" means the hospital commission of the state of Washington as created by this chapter;

(2) "Consumer" means any person whose occupation is other than the administration of health activities or the providing of health services, who has no fiduciary obligation to a health facility or other health agency, and who has no material financial interest in the rendering of health services;

(3) "Hospital" means any health care institution which is required to qualify for a license under RCW 70.41.020(2); or as a psychiatric hospital under chapter 71.12 RCW, but shall not include any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination. [1973 1st ex.s. c 5 § 3.]

70.39.030 Hospital commission——Created——Membership. There is hereby created a hospital commission, which shall be a separate and independent commission of the state. The commission shall be composed of five members appointed by the governor, and generally representative of the public as consumers, labor, business, and hospitals, and shall be individuals concerned with the delivery of quality health care; but in no event shall more than two members have any fiduciary obligation to a health facility or other health agency, nor any direct financial interest in the rendering of health services. In cases when proposed rate increases for osteopathic hospitals are to be considered, the representative of osteopathic hospitals on the technical advisory committee shall replace a hospital representative on the commission. [1973 1st ex.s. c 5 § 4.]

70.39.040 Hospital commission——Terms——Vacancies. Members of the commission shall serve for four-year terms: *Provided*, That upon the expiration of the initial four-year terms, two persons shall be appointed for three-year terms and three persons for four-year terms and thereafter all members of the commission shall serve for four-year terms. Appointments shall require senate confirmation. No member shall serve on the commission for more than two consecutive terms. A vacancy shall be filled by appointment for the remainder of the unexpired term and the initial appointments and vacancies shall not require senate confirmation until the legislature next convenes. [1977 c 36 § 1; 1973 1st ex.s. c 5 § 5.]

70.39.050 Hospital commission——Officers——Meetings——Compensation. The member representing consumers of health care services shall serve as chairman. The commission shall elect from its members a vice-chairman biennially. Meetings of the commission shall be held as frequently as its duties require. The commission shall keep minutes of its meetings and adopt procedures for the governing of its meetings, minutes, and transactions.

Three members shall constitute a quorum, but a vacancy on the commission shall not impair its power to act. No action of the commission shall be effective unless three members concur therein.

The members of the commission shall receive no compensation but shall be reimbursed for their expenses while attending meetings of the commission in the same manner as legislators engaged in interim committee business as in RCW 44.04.120. [1973 1st ex.s. c 5 § 6.]

70.39.060 Hospital commission——Director——Secretary——Staff——Services. The commission shall appoint a full time executive director and a deputy director and confidential secretary who shall be exempt from the civil service law, chapter 41.06 RCW and who shall perform the duties delegated by the commission. The executive director shall be the chief administrative officer of the commission and shall be subject to its direction.

The commission shall employ such other staff as are necessary to fulfill the responsibilities and duties of the commission, such staff to be subject to the civil service law, chapter 41.06 RCW, and under the supervision of the executive director. In addition, the commission may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise.

Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractu responsibility, without specific permission of th commission.

The commission may apply for and receive and acce grants, gifts, and other payments, including property ar service, from any governmental or other public or pi vate entity or person, and may make arrangements as the use of these receipts, including the undertaking special studies and other projects relating to hospit health care costs. [1977 c 35 § 1; 1973 1st ex.s. c 5 §

70.39.070 Technical advisory committee——Mer bers——Terms——Officers——Meetings——Expens In order to assist the commission in carrying out duties, the governor shall appoint a technical adviso committee, hereinafter referred to as "committee which shall consist of eleven members as follows:

(1) One member who shall be a certified pub accountant licensed pursuant to chapter 18.04 RCW a who shall be knowledgeable in the financial affairs hospitals.

(2) One member who shall be a health care practitioner licensed under the laws of this state and who shall be knowledgeable in hospital administration.

(3) Five members who shall be representative of the interest of investor-owned, district, not-for-profit, osteopathic, and university hospitals.

(4) One member who shall be representative of consumers of health care.

(5) One member who shall be the secretary of the department of social and health services, or his designee, to provide continuing liaison, data and support from those functions of the department which may affect the responsibilities of the commission.

(6) One member who shall be the director of the planning and community affairs agency, or his designee, to provide continuing liaison with the planning efforts of the comprehensive health planning council.

(7) One member of the commission, elected by the commission.

The members shall serve concurrently and shall have four-year terms. Any vacancy shall be filled by appointment by the governor and an appointee selected to fill such vacancy shall hold office for the balance of the term for which his predecessor was appointed. The committee shall elect from its members a chairman and a vice-chairman to serve concurrently with the chairman. The executive director of the commission shall act as executive secretary to the committee, and the commission shall otherwise offer such staff services and supplies as the committee may require to carry out its responsibilities.

The committee shall meet on call of the chairman of the commission, or on request of a majority of the commission. Members of the committee shall serve without compensation but shall be reimbursed for their expenses in the same manner as members of the commission. [1973 1st ex.s. c 5 § 8.]

70.39.080 Technical advisory committee——Duties. The committee shall have the duty upon the request of the commission to consult with and make recommendations to the commission:

(1) On matters of policy;

(2) On rules and regulations proposed by the commission to implement this chapter;

(3) On analyses and studies of hospital health care costs and related matters which may be undertaken by the commission; and

(4) On such other matters as the commission may refer. [1973 1st ex.s. c 5 § 9.]

70.39.090 Hospital commission——Subcommittees. To further the purposes of this chapter, the commission may create committees from its membership, and may create such ad hoc advisory committees in specialized fields, related to the functions of hospitals, as it deems necessary, to supplement the resources provided by the technical advisory committee. [1973 1st ex.s. c 5 § 10.]

70.39.100 Uniform system of hospital accounting and reporting. (1) The commission, after study and in consultation with advisory committees, if any, shall establish by the promulgation of rules and regulations pursuant to the Administrative Procedure Act, chapter 34.04 RCW, a uniform system of accounting and financial reporting, including such cost allocation methods as it may prescribe, by which hospitals shall record their revenues, expenses, other income, other outlays, assets and liabilities, and units of service. All hospitals shall adopt the system for their fiscal year period to be effective at such time and date as the commission shall direct. In determining the effective date for reporting requirements, the commission shall be mindful both of the immediate need for uniform hospital reporting information to effectuate the purposes of this chapter and the administrative and economic difficulties which hospitals may encounter in conversion, but in no event shall such effective date be later than two and one-half years from the date of the formation of the commission.

(2) In establishing such accounting systems and uniform reporting procedures, the commission shall take into consideration:

(a) Existing systems of accounting and reporting presently utilized by hospitals;

(b) Differences among hospitals according to size; financial structure; methods of payment for services; and scope, type, and method of providing services; and

(c) Other pertinent distinguishing factors.

(3) The commission shall, where appropriate, provide for modification, consistent with the purposes of this chapter, of reporting requirements to correctly reflect these differences among hospitals, and to avoid otherwise unduly burdensome costs in meeting the requirements of the uniform system of accounting and financial reporting.

(4) The accounting system, where appropriate, shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred with reference to educational research and other nonpatient-related activities including but not limited to charitable activities of such hospitals. [1973 1st ex.s. c 5 § 11.]

70.39.110 Annual reports by hospitals. (1) Each hospital shall file annually with the commission after the close of the fiscal year:

(a) A balance sheet detailing the assets, liabilities, and net worth of the hospital;

(b) A statement of income and expenses;

(c) Such other reports of the costs incurred in rendering services as the commission may prescribe.

(2) Where more than one licensed hospital is operated by the reporting organization, the information required by this section shall be reported for each hospital separately.

(3) The commission shall require certification of specified financial reports by the hospital's certified public accountant, and may require attestation as to such statements from responsible officials of the hospital that such reports have to the best of their knowledge and belief been prepared in accordance with the prescribed system of accounting and reporting.

(4) All reports, except privileged medical information, filed under this chapter shall be open to public inspection.

(5) The commission shall have the right of inspection of hospital books, audits, and records as reasonably necessary to verify hospital reports. [1973 1st ex.s. c 5 § 12.]

70.39.120 Hospital costs and finances——Analyses and studies——Reports. (1) The commission shall from time to time undertake analyses and studies relating to hospital health care costs and to the financial status of any hospital or hospitals subject to the provisions of this chapter, and may publish and disseminate such information as it deems desirable in the public interest. It shall further require the filing of information concerning the total financial needs of each hospital and the resources available or expected to become available to meet such needs, including the effect of proposals made by area-wide and state comprehensive health planning agencies.

(2) The commission shall also prepare and file such summaries and compilations or other supplementary reports based on the information filed with the commission hereunder as will advance the purposes of this chapter. [1973 1st ex.s. c 5 § 13.]

70.39.130 Report to governor and legislature. The commission shall prepare and, prior to each legislative session beginning in January, transmit to the governor and to the legislature an annual report of commission operations and activities for the preceding fiscal year. This report shall include such findings and recommendations as the commission deems necessary. [1977 c 75 § 82; 1973 1st ex.s. c 5 § 14.]

70.39.140 Hospital rates——Review and investigation——Costs——Establishment of rates——Coordination with federal programs. From and after a date not less than twelve months but not more than twenty-four months after the adoption of the uniform system of accounting and financial reporting required by RCW 70.39.100, as the commission may direct, the commission shall have the power to initiate such reviews or investigations as may be necessary to assure all purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered by that hospital, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs; and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference.

In order to properly discharge these obligations, the commission shall have full power to review projected annual revenues and approve the reasonableness of rates proposed to generate that revenue established or requested by any hospital subject to the provisions of this chapter. No hospital shall charge for services at rates other than those established in accordance with the procedures established hereunder.

In the interest of promoting the most efficient and effective use of hospital health care service, the commission may promote and approve alternative methods of rate determination and payment of an experimental nature that may be in the public interest and consistent with the purposes of this chapter.

The commission shall serve as the state agency responsible for coordinating state actions and otherwise responding and relating to the efforts of the cost of living council, or its successor, in planning and implementing federal cost containment programs with respect to hospitals and related health care institutions as authorized by the Federal Economic Stabilization Act of 1970, as now or hereafter amended, and any rules or regulations promulgated thereto. In carrying out this responsibility, the commission may serve as the state agency responsible for recommending increases in rates for hospitals and related health care institutions to the cost of living council, or its successor; may apply to the cost of living council for authorization to administer a control program in Washington state in lieu of the federal controls established and otherwise administered by the cost of living council; may assume another function or role authorized by appropriate federal regulations implementing the Federal Economic Stabilization Act of 1970; or assume any combination of such roles or functions as it may determine will most effectively contain the rising costs of the varying kinds of hospitals and related health care institutions in Washington state. In determining its functions or roles in relation to the efforts to the cost of living council, or its successor, the commission shall seek to ensure coordination, and the reduction of duplicatory cost containment efforts, by the state and federal governments, as well as the diligent fulfillment of the purposes of this chapter and declared public policy and legislative intent herein: *Provided, however,* That in cases where the rates of nursing homes or similar health institutions are subject to review pursuant to the provisions of the Federal Economic Stabilization Act of 1970 or any rules or regulations promulgated thereto, the members of the commission representing hospitals shall not sit in the proceedings nor vote, and the governor shall appoint an ad hoc member representing nursing homes or similar health institutions in lieu thereof, who shall have the same powers as the other members with respect to such review only. [1974 ex.s. c 163 § 1; 1973 1st ex.s. c 5 § 15.]

70.39.150 Powers and duties of commission. To properly carry out its authority the commission shall:

(1) Compile all relevant financial and accounting data in order to have available the statistical information necessary to properly conduct rate review and approval. Such data shall include necessary operating expenses, appropriate expenses incurred for rendering services to patients who cannot or do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on the expected useful life of the property and equipment involved. The commission shall define and prescribe by rule and regulation the types and classes of charges which cannot be changed except as provided by the procedure contained in RCW 70.39.160 and it shall also obtain from each such hospital a current rate schedule as well as any subsequent amendments or modifications of that schedule as it may HOSPITAL COMMISSION

(2) Permit any nonprofit hospital subject to the provisions of this chapter to charge reasonable rates which will permit the hospital to render effective and efficient service in the public interest and on a solvent basis.

(3) Permit any proprietary profit-making hospital subject to the provisions of this chapter to charge reasonable rates which will permit the hospital to render effective and efficient service in the public interest and which includes an allowance for a fair return to stockholders based upon actual investment or, if the hospital elects, upon the fair value of the investment on the effective date of this section: *Provided,* That once the election is made it may not be changed without the approval of the commission.

(4) Take into account, in the determination of reasonable rates under this section for each hospital, the recommendations of appropriate area-wide and state comprehensive health planning agencies to ensure compliance with Washington comprehensive health planning law, chapter 70.38 RCW.

(5) Permit, in considering a request for change in or initiating a review of rate schedules or other charges, any hospital subject to the provisions of this chapter to charge rates which will in the aggregate produce sufficient total revenue for the hospital to meet all of the reasonable obligations specified in this chapter. [1977 1st ex.s. c 154 § 1; 1973 1st ex.s. c 5 § 16.]

70.39.160 Changes in rates——Procedure. From and after the date determined by the commission pursuant to RCW 70.39.140, no hospital subject to the provisions of this chapter shall change or amend that schedule of rates and charges of the type and class which cannot be changed without prior approval of the commission, except in accordance with the following procedure:

(1) Any request for a change in rate schedules or other charges must be filed in writing in the form and content prescribed by the commission and with such supporting data as the hospital seeking the change deems appropriate. Unless the commission orders otherwise as provided for in subsection (4) of this section, no

hospital shall establish such changes except after notice to the commission of at least thirty days from the time the rate is intended to go into effect. Upon receipt of notice, the commission may suspend the effective date of any proposed change. In any such case a formal written statement of the reasons for the suspension will be promptly submitted to the hospital. Unless suspended, any proposed change shall go into effect upon the date specified in the application.

(2) In any case where such action is deemed necessary, the commission shall promptly, but in any event within thirty days, institute proceedings as to the reasonableness of the proposed changes. The suspension may extend for a period of not more than thirty days beyond the date the change would otherwise go into effect: *Provided*, That should it be necessary, the commission may extend the suspension for an additional thirty days. After the expiration of ninety days from the date the rate is intended to go into effect the new rate will go into effect, if the commission does not approve, disapprove, or modify the request by that time.

(3) Such proposed changes shall be considered at a public hearing, the time and place of which shall be determined by the commission. The hearing shall be conducted by the commission. Evidence for and against the requested change may be introduced at the time of the hearing by any interested party and witnesses may be heard. The hearing may be conducted without compliance with formal rules of evidence.

(4) The commission may, in its discretion, permit any hospital to make a temporary change in rates which shall be effective immediately upon filing and in advance of any review procedure when it deems it in the public interest to do so. Notwithstanding such temporary change in rates, the review procedures set out in this section shall be conducted by the commission as soon thereafter as is practicable.

(5) Every decision and order of the commission in any contested proceeding shall be in writing and shall state the grounds for the commission's conclusions. The effects of such orders shall be prospective in nature. [1973 1st ex.s. c 5 § 17.]

70.39.170 Budget——Expenses——Assessments——Hospital commission account. The commission shall biennially prepare a budget which shall include its estimated income and expenditures for administration and operation for the biennium, to be submitted to the governor for transmittal to the legislature for approval.

Expenses of the commission shall be financed by assessment against hospitals in an amount to be determined biennially by the commission, but not to exceed four one-hundredths of one percent of each hospital's gross operating costs to be levied and collected from and after July 1, 1973 for the provision of hospital services for its last fiscal year ending on or before June 30th of the preceding calendar year. Budgetary requirements in excess of that limit may be financed by a general fund appropriation by the legislature. All moneys collected are to be deposited by the state treasurer in the hospital commission account in the general fund which is hereby created.

Any amounts raised by the collection of assessments from hospitals provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the commission in succeeding years. [1973 1st ex.s. c 5 § 18.]

70.39.180 Rules and regulations——Public hearings——Investigations——Subpoena power. In addition to the powers granted to the commission elsewhere in this chapter, the commission may:

(1) Adopt, amend, and repeal rules and regulations respecting the exercise of the powers conferred by this chapter, subject to the provisions of the Administrative Procedure Act, chapter 34.04 RCW applicable to the promulgation of rules and regulations.

(2) Hold public hearings, conduct investigations, and subpoena witnesses, papers, records, and documents in connection therewith. The commission may administer oaths or affirmations in any hearing or investigation.

(3) Exercise, subject to the limitations and restrictions herein imposed, all other powers which are reasonably necessary or essential to carry out the expressed objects and purposes of this chapter. [1973 1st ex.s. c 5 § 19.]

70.39.190 Review. Any person aggrieved by a final determination of the commission as to any rule, regulation, or determination under the provisions of this chapter shall be entitled to an administrative hearing and judicial review in accordance with the Administrative Procedure Act, chapter 34.04 RCW. [1973 1st ex.s. c 5 § 20.]

70.39.200 Penalties for violations. Every person who shall violate or knowingly aid and abet the violation of this chapter or any valid orders, rules, or regulations thereunder, or who fails to perform any act which it is herein made his duty to perform shall be guilty of a misdemeanor. Following official notice to the accused by the commission of the existence of an alleged violation, each day upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of this chapter may be enjoined from continuing such violation. [1973 1st ex.s. c 5 § 21.]

70.39.900 Severability——1973 1st ex.s. c 5. If any provision of this 1973 act, or its application to any person or circumstance is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected. [1973 1st ex.s. c 5 § 22.]

70.39.910 Liberal construction——1973 1st ex.s. c 5. Consistent with the purposes enumerated in RCW 70.39.010, the provisions of this chapter shall be liberally construed, and shall not be limited by any rule of strict construction. [1973 1st ex.s. c 5 § 23.]

Reviser's note: The effective date of 1977 1st ex.s. c 154 § 1 was September 21, 1977 (midnight September 20); see preface 1977 session laws.

APPENDIX B

Rules Adopted - Washington State Hospital Commission

TRANSMITTAL OF RULES ADOPTED

FROM: Washington State Hospital Commission
(Name of Agency)

TO: CODE REVISER
LEGISLATIVE BLDG. (Southwest Corner, Ground Floor)
OLYMPIA 98504

The enclosed rules Permanent rules ☒ , being Order No. 75-05
Emergency rules ☐

relating to (Name of rules or description of subject matter)

Adopting Ch. 261.40 WAC -- Regulations relating to the Review and Approval of Annual Budget Submittals, Rates, Rate Schedules, Other Charges and Changes Therein

(ALTERNATIVE A. Use only for adoption of permanent rules)

pursuant to Notice No. 5555 ① filed with the code reviser on 10/24/75 (date) ② were regularly adopted as permanent rules of this agency at Seattle, Washington (place) on 11/6/75 (date) and are herewith filed in the office of the code reviser pursuant to chapter 34.04 RCW. The effective date of such rules shall be 12/10/75 .③

(ALTERNATIVE B. Use only for adoption of emergency rules)

pursuant to its finding in the attached administrative order, that the immediate adoption of these rules is necessary for the preservation of the public health, safety, or general welfare and that observance of the requirements of notice and opportunity to present views on the proposed action would be contrary to the public interest, were regularly adopted as emergency rules of this agency at _____ (place) on _____ (date) and are herewith filed in the office of the code reviser pursuant to chapter 34.04 RCW.

The undersigned hereby certifies that the requirements of chapter 34.04 RCW and of the Open Public Meetings Act of 1971, chapter 42.30 RCW have been fulfilled.

Dated this tenth day of November 1975.

STATE OF WASHINGTON
FILED
NOV 10 1975
CODE REVISER'S OFFICE
DOCKET # ___ FILE # ___

Washington State Hospital Commission
(AGENCY)

By Francis D. Baker

Executive Director
Title

①Notice number as appears on the copy of notice returned to you by reviser's office (if proceedings were continued, use no. of last notice)
②Stamped date as appears on the copy of notice returned to you by reviser's office (if proceedings were continued, use date of last notice
③Unless a later date is specified in this order or is prescribed in another statute, rules are effective 30 days after filing: RCW 34.04.040. Leave this space blank except in such special cases.

[Order 9, filed 9/25/74, eff. 10 25/74] [Form CR-2: Rev. 9/21/74]

WASHINGTON STATE HOSPITAL COMMISSION

RESOLUTION NO. 75-05

Administrative Order No. 75-05

A RESOLUTION Relating to permanent rules of the Washington State Hospital Commission.

BE IT RESOLVED BY THE WASHINGTON STATE HOSPITAL COMMISSION

Section 1. The annexed regulations, to-wit:

Chapter 261-40, Washington Administrative Code: Review and Approval of Annual Budget Submittals, Rates, Rate Schedules, Other Charges and Changes Therein

are hereby approved and adopted as permanent rules of the Washington State Hospital Commission.

Section 2. This resolution and annexed regulations, after being first recorded as an administrative order in the Order Register of the Washington State Hospital Commission shall be forwarded to the Code Reviser for filing pursuant to Ch. 34.04 RCW and WAC 1-12-050.

APPROVED AND ADOPTED November 10, 197

Attest:

Francis D. Baker
Executive Director

Chapter 261-40

REVIEW AND APPROVAL OF ANNUAL BUDGET SUBMITTALS, RATES, RATE SCHEDULES, OTHER CHARGES AND CHANGES THEREIN

PART 0
GENERAL PROVISIONS

WAC 261-40-010 PURPOSE. The purpose of this chapter is to implement the provisions of RCW 70.39.140 through .160 regarding the Commission's review and approval of annual budget submittals, hospital rates, rate schedules, other charges, and changes therein. The Commission's objective is to assure purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered by that hospital, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs, and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference.

WAC 261-40-015 DEFINITIONS. As used in this chapter, unless the context requires otherwise:

(1) "Annual budget submittal" and "submittal" mean the information submitted to the Commission pursuant to WAC 261-30-040.

(2) "Washington State Hospital Commission" and "Commission" mean the Washington State Hospital Commission created by Ch. 70.30 RCW.

(3) "Hospital" means any health care institution which is required to qualify for a license under RCW 70.41.020(2); or as a psychiatric hospital under Ch. 71.12 RCW, but shall not include any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination. The term "hospital" also refers to an entity that has submitted to the Commission an annual budget submittal, which submittal is subject to review by the staff and Commission in accordance with the provisions of this chapter.

(4) "Person" or "party" when used in this chapter means any individual, partnership, corporation, comprehensive health planning agency created pursuant to Ch. 70.38 RCW, hospital as defined in Ch. 70.39 RCW, or any body politic or municipal corporation.

(5) "Rate" means the revenue per defined unit of service for each revenue center identified in the Commission's publication entitled Accounting and Reporting Manual for Hospitals adopted under Ch. 261-30 WAC.

(6) "Staff" means the Executive Director, Deputy Director and Confidential Secretary of the Commission, as well as the employees of the Department of Social and Health Services furnished the Commission pursuant to RCW 70.30.060 to carry out its duties.

WAC 261-40-020 APPLICABILITY OF THIS CHAPTER. (1) Required Commission approval of rate changes: No rate described in any hospital's annual budget submittal and approved by the Commission may be changed by such hospital without applying to the Commission for the approval of a rate change in accordance with the procedures set forth in this chapter.

(2) Required use of approved rates: Hospitals shall utilize only those rates that have been approved by the Commission.

(3) Public hearing on initial annual budget submittal: Since no hospital will have utilized the rate concept adopted by the Commission under Ch. 261-30 WAC prior to preparation and submission of its initial annual budget submittal, the rates proposed therein will constitute "new" rates. As such, they will be deemed by the Commission to propose a change in rates subject to Commission review in a public hearing in accordance with RCW 70.39.160.

WAC 261-40-025 INAPPLICABILITY OF UNIFORM PROCEDURE RULES. Matters subject to review and action by the Commission under this chapter shall be subject to the procedural rules set forth herein as well as the Uniform Procedure Rules set forth in Ch. 1-08 WAC and adopted by the Commission in Ch. 261-08 WAC, PROVIDED, that where the latter rules are inconsistent with provisions contained herein, the provisions of this chapter shall apply.

WAC 261-40-030 SUSPENSION OF PROPOSED EFFECTIVE DATE OF RATE, RATE SCHEDULE, OTHER CHARGES, OR ANY CHANGE THEREIN.

(1) General: Under RCW 70.39.160, the Commission is authorized to suspend the effective date of a rate, rate schedule, other charge, or any change therein prposed by a hospital in its annual budget submittal. Any such suspension is a totally discretionary act by the Commission. A written explanation of the reasons for such Commission action will be provided to the hospital promptly following such action.

(2) Reasons for suspension: It shall be the policy of the Commission to review and process annual budget submittals proposing rates, rate schedules, other charges, and any changes therein within a timely fashion so as to avoid having to suspend the proposed effective date thereof. Nevertheless, the Commission may choose to suspend the proposed effective date of any rate, rate schedule, other charge, or any change therein for any of the following reasons:

(a) The hospital has failed to submit information or a modified or corrected annual budget submittal within the time period specified by the staff; or has requested a continuance in a hearing.

(b) The staff needs additional time to properly review and process the submittal for good cause shown by the staff;

(c) Other just causes or reasons.

(3) Period of suspension: The initial suspension subsequently shall be for not more than thirty days. The Commission may subsequently suspend the effective date of any rate, rate schedule, other charge, or any change therein for an additional period not to exceed thirty days.

(4) Notice of suspension to hospital: Whenever the Commission suspends the effective date of any proposed rate, rate schedule, other charge, or changes therein, it shall immediately notify in writing the hospital subject to suspension of such Commission action and the period thereof.

PART I
ANNUAL BUDGET SUBMITTAL REVIEW PROCESS

WAC 261-40-100 RECEIPT OF ANNUAL BUDGET SUBMITTAL. (1) Date stamped upon receipt: Every annual budget submittal provided the Commission pursuant to RCW 70.39.120 and .140 and WAC 261-30-040, shall be stamped as to the date of receipt upon receipt in the Commission's office.

(2) Acknowledgement of receipt: The receipt in the Commission's office, and date thereof, of a hospital's annual budget submittal shall be acknowledged by the staff in written notice to such hospital. Such notice shall also indicate the date the staff expect such annual budget submittal will be considered by the Commission in an informal hearing.

WAC 261-40-105 TIME LIMITATIONS ON STAFF FOR REVIEW OF ANNUAL BUDGET SUBMITTAL FOR COMPLETENESS AND CONFORMANCE, AND VERIFICATION OF DATA. Within thirty days after receipt of an annual budget submittal, the staff shall determine whether it is complete and conforms to Commission regulations, policies, and instructions; and verify the data contained therein.

WAC 271-40-110 NOTICE REGARDING ANNUAL BUDGET SUBMITTAL'S COMPLETENESS, CONFORMANCE, AND VERIFIABILITY OF DATA; TIME FOR RESPONSE TO NOTICE; EFFECT OF LACK OF NOTICE. (1) Notice: Written notice shall be provided by mail or telegram to a hospital within the review period specified in WAC 261-40-105 in the event the staff determines the annual budget submittal of such hospital is incomplete; fails to conform with Commission regulations, policies, or instructions; or contains data that cannot be verfied. Such notice shall clearly indicate the deficiencies found, the corrections or modifications that must be made in said submittal to make it complete or conforming or its data verifiable, as well as the time by which a corrected or modified submittal must be received in the Commission's office.

(2) Time for response to notice: In no event, shall a hospital be provided less than seven days following receipt of notice, to return to the Commission's office the requested corrected or modified submittal.

(3) Effect of lack of notice to hospital: A hospital not notified as provided in WAC 261-40-110(1) shall be deemed to have submitted an annual budget submittal that is complete and conforming, and has verifiable data.

WAC 261-40-115 EFFECT OF RESPONSE TO NOTICE WITHIN SPECIFIED TIME PERIOD. In the event such corrected or modified submittal is returned to the Commission's office within the specified time period (generally, a period of seven days) the staff shall make a reasonable effort to continue the processing of such submittal as if there had been no delay; the Commission, however, may still suspend the effective date of a proposed rate, rate schedule, or other charge, for the reasons set forth in WAC 261-40-030.

WAC 261-40-120 EFFECT OF DETERMINATION THAT ANNUAL BUDGET SUBMITTAL IS COMPLETE AND CONFORMING, AND CONTAINS VERIFIABLE DATA. Whenever the staff determines the annual budget submittal is complete and conforming, it shall commence its process of verifying the data contained in such submittal. Whenever the staff determines the data contained in such submittal is verifiable it shall complete its processing of the submittal and prepare its recommendations to the Commission regarding such submittal.

WAC 261-40-125 CRITERIA FOR DETERMINING COMPLETENESS, CONFORMANCE, AND VERIFIABILITY OF DATA. (1) An annual budget submittal shall be deemed

(a) "Complete", when it contains all data required by the Commission pursuant to Ch. 261-30 WAC and this chapter, including information in response to special information requests made by the Commission pursuant to WAC 261-40-130; and

(b) "In conformance" when it has been prepared in the form and manner specified by the Commission and otherwise conforms to the requirements of Commission regulations, policies, and any instructions regarding annual budget submittals in effect at the time such submittal was submitted to the Commission.

(2) The data contained in a hospital's annual budget submittal shall be deemed verifiable when such data is properly included in appropriate Commission forms; figures reconcile to proper balances; the statistical bases of computations, extensions, footings, etc. test out; and other statistical and financial examinations established by the staff to measure data verifiability show the data to be verifiable.

WAC 261-40-130 SPECIAL INFORMATION REQUESTS. In the event the staff desires additional information not provided by a hospital in its annual budget submittal, a written request detailing the additional information to be provided the staff will be mailed to the hospital during the review period. The failure of a hospital to respond to such information requests in a timely manner may result in the suspension of the effective date of, or the modification or disapproval of proposed rates, rate schedules, other charges, or changes therein.

WAC 261-40-135 STAFF FINDINGS AND RECOMMENDATION REGARDING ANNUAL BUDGET SUBMITTAL. (1) Contents: Upon completion of the staff review of a hospital's annual budget submittal, the staff shall prepare a written statement of its findings and recommendations to the Commission. Such statement shall include:

(a) An analysis of the annual budget submittal in such form as the Commission shall direct, as corrected or modified by the hospital in response to WAC 261-40-110(1) notice;

(b) A description of the exceptions noted in the primary, secondary, or detailed expense screening process used by the staff together with any explanation or justification provided by the hospital or determined by the staff for such exception;

(c) Recommendations of the staff regarding the rates, rate schedules, other charges, or changes therein proposed in the annual budget submittal; and

(d) Such other matters as the staff deems appropriate.

(2) Date of providing of statement: A copy of the staff's statement shall be mailed to the hospital not less than fifteen days prior to the date last set for Commission consideration of the hospital's annual budget submittal. Copies of the statement also shall be provided to Commission members by that same date.

WAC 261-40-140 NOTICE TO PUBLIC REGARDING ANNUAL BUDGET SUBMITTAL FINDINGS AND RECOMMENDATIONS AND PUBLIC HEARING. Not less than fifteen days prior to the date last set for Commission consideration of a hospital's annual budget submittal, the staff shall provide such notice to the general public as the Commission shall direct regarding the impending hearing. Such notice shall indicate the receipt by the Commission of the hospital's annual budget submittal; the preparation of staff findings, and recommendations to the Commission regarding such submittal; the availability of such material in the Commission's office for inspection and copying pursuant to Ch. 261-06 WAC; the setting of a date, time, and place for Commission consideration of such material together with any further response to the staff findings and recommendations subsequently submitted by the hospital; and the opportunities of the general public not only to present written testimony for or against the rates, rate schedules, other charges, or changes therein, or directly related matters before the Commission, but also to attend such hearing.

WAC 261-40-145 HOSPITAL'S RESPONSE TO STAFF FINDINGS AND RECOMMENDATIONS; WRITTEN TESTIMONY FROM GENERAL PUBLIC, TIME FOR SUBMISSION. A hospital may submit to the Commission a response to the staff findings and recommendations. Such response, any any written testimony from the general public submitted pursuant to WAC 261-40-140 notice, must be received in the Commission's office not less than three days prior to the date last set for Commission consideration of the hospital's annual budget submittal. A hospital's response and any written testimony from the general public received after that date may not be considered by the Commission.

WAC 261-40-150 CRITERIA FOR APPROVAL, MODIFICATION, OR DISAPPROVAL OF ANNUAL BUDGET SUBMITTAL AND RATES, RATE SCHEDULES, OTHER CHARGES, AND CHANGES THEREIN. The following criteria shall be utilized by the Commission in reviewing and acting on annual budget submittals pursuant to Ch. 70.39 RCW and this chapter; the weighting of each criterion listed below, however, is a matter of Commission discretion:

(1) Whether the hospital's annual budget submittal and the rates, rate schedules, other charges, and changes therein:

(a) Are such that the Commission can assure all purchasers of that hospital's health care services that the total costs of the hospital are reasonably related to the total services offered by that hospital;

(b) Are such that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs;

(c) Are such that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference.

(2) Whether the Commission action will permit a non-profit hospital to render effective and efficient service in the public interest and on a solvent basis.

(3) Whether the Commission action will permit a proprietary profit-making hospital to render effective and efficient service in the public interest as well as allow such hospital's shareholders a fair return based upon actual investment or the fair value of the investment, whichever is less.

(4) Whether the appropriate area-wide and state comprehensive health planning agencies have recommended approval, modification, or disapproval of the annual budget submittal, or the rates, rate schedules, other charges, or changes therein.

(5) Whether the hospital's annual budget submittal and the rates, rate schedules, other charges, and changes therein will in the aggregate produce sufficient total revenue for the hospital to meet all of the reasonable obligations specified in Ch. 70.39 RCW.

(6) Whether the rates, rate schedules, other charges, and changes therein contained in the hospital's annual budget submittal are reasonable.

WAC 261-40-160 APPROVAL OF RATES FOR LESS THAN FULL FISCAL YEAR. The Commission, in its discretion, may grant approval of rates as submitted in a hospital's annual budget submittal or as modified by the Commission, either for the full fiscal year of the hospital or any period less than than period. The decision and order of the Commission notifying a hospital of such action shall specify the period of time within which the hospital may utilize the approved rates as well as what action (if any) must be taken by the hospital to secure Commission approved rates after the specified period.

PART II
GENERAL PROCEDURES APPLICABLE TO ALL COMMISSION HEARINGS REGARDING ANNUAL BUDGET SUBMITTALS

WAC 261-40-200 CONTINUANCES. Any person who desires a continuance shall, immediately upon receipt of notice of the hearing, or as soon thereafter as facts requiring such continuance come to his/her knowledge, notify the Commission of said desire, stating in detail the identification constituting an appearance pursuant to WAC 261-40-300 if he/she has not made an appearance, as well as the reasons why such continuance is necessary. The Commission, or presiding officer in a formal hearing, in passing upon a request for a continuance shall consider

whether such request was promptly made. Except in cases of hardship or unless good cause is shown, no such continuance shall be granted unless such a request is made to the Commission at least three days preceding the date upon which the matter is set for hearing. The Commission may grant such a continuance and may at any time order a continuance upon its own motion. During the hearing, if it appears in the public interest that further testimony or argument should be received, the presiding officer may in his/her discretion continue the hearing and fix the date for introduction of additional testimony or presentation of argument. Such oral notice shall constitute final notice of such continued hearing. The granting of a continuance by the Commission may result in a concurrent suspension of the effective date of proposed rates.

WAC 261-40-205 CONDUCT AT HEARINGS. All parties to hearings, their counsel, and spectators shall conduct themselves in a respectful manner. Demonstrations of any kind at hearings shall not be permitted.

WAC 261-40-210 ORDER OF PROCEDURE. Requests for the suspension of the effective date of proposed rates, rate schedules, other charges, or changes therein contained in an annual budget submittal; and requests for continuances shall be considered first in any hearing regarding annual budget submittals. Testimony may be given to the Commission ordinarily in the following order:

(i) The hospital or petitioners,
(ii) Staff,
(iii) Protestants, and
(iv) Rebuttal by the hospital or petitioners.

Intervenors shall follow the party in whose behalf the intervention is made. If the intervention is not in support of either the hospital or petitioners, or the staff, the presiding officer shall designate the point during the hearing such intervenors shall be heard. When two or more annual budget submittals are set for hearing at the same time and place, the submittal first having been received in the Commission's office shall first be heard, if all parties thereto are ready; PROVIDED, presentations and testimony to the Commission during informal hearings shall be given in the following order:

(i) The summarization of the annual budget submittal and presentation of staff findings and recommendations by the Executive Director or his designee;
(ii) The response thereto by representative(s) of the hospital;
(iii) Answers to questions of Commission members by the staff and hospital represatives;
(iv) The comments by the general public and protestants;
(v) Rebuttal thereto by the nospital representative(s) or staff;

AND PROVIDED, FURTHER, That the presiding officer may direct a different order to suit the convenience of the parties.

WAC 261-40-215 NUMBER OF WITNESSES AND DURATION OF TESTIMONY MAY BE LIMITED. In all proceedings before the Commission, the presiding officer shall have the right, in his/her discretion, to limit not only the number of people making presentations or witnesses testifying upon any subject or proceeding before the Commission, but also the length of time allowed for presentations and the giving of testimony, provided sufficient testimony has been received to enable the Commission to render a fair and impartial decision.

WAC 261-40-220 RULES OF EVIDENCE. (1) General: In accordance with the provisions of RCW 70.39.160(3), formal rules of evidence shall not apply to matters coming before the Commission. During informal and formal hearings, the Commission, in its discretion, either with or without objection, shall determine whether testimony or evidence presented to it for consideration is admissible for consideration. Generally, the Commission will consider any relevant testimony or evidence presented to it in an informal hearing. Objections to the admissibility of such testimony or evidence, based on formal rules of evidence, generally will not be sustained by the Commission; when objection is made to the admissibility of evidence, however, such evidence may be received subject to later ruling by the Commission. Parties objecting to the introduction of evidence shall state the grounds of such objectives at the time such evidence is offered. In any hearing the presiding officer may, in his/her discretion, either with or without objection, order cumulative evidence discontinued.

(2) Official notice: In addition to matters which courts of this state may take judicial notice and those matters specified in WAC 1-08-370 and -380, official notice may be taken of the following matters: by the Commission in informal hearings, and by the presiding officer or hearing examiner in formal hearings, respectively:

(a) Rules, regulations, administrative rulings and orders, exclusive of findings of fact, of the Commission and other governmental agencies;

(b) Contents of certificates, permits and licenses inssued by the Commission or other governmental agencies;

(c) Rates, classifications, and schedules established or approved by the Commission.

In addition, upon request by all parties to the proceeding so to do, official notice may be taken of the results of the Commission's own inspection of the physical conditions involved. With or without being requested by a party so to do, official notice may be taken of the results of previous Commission experience in similar situations, and the general information concerning the subject which goes to make up the Commission's fund of expert knowledge. Where official notice is taken of any matter, the findings of fact shall so specify and shall state the basis upon which notice is taken.

(3) Resolutions: Resolutions, properly authenticated, of the governing bodies of cities, towns, other municipal corporations, and of comprehensive health planning agencies and associations of hospitals will be received in evidence if offered by the president, secretary or other proper officer in person at the hearing, provided such officer was present when the resolution was passed. Such resolution shall be received subject to rebuttal by adversely affected parties as to either the authenticity of

the resolution or the circumstances surrounding its procurement. Recitals of facts contained in resolutions shall not be deemed proof of those facts.

WAC 261-40-225 EXHIBITS AND DOCUMENTARY EVIDENCE. (1) Size of exhibits: Except by special permission of the presiding officer no specially prepared exhibit offered as evidence shall be of greater size when folded than 8 1/2 inches by 13 inches: PROVIDED, That maps of greater size, necessary to a presentation of evidence; and Commission reports and forms of greater size, whether completed by a hospital or the staff, are admissible.

(2) Designation of part of document as evidence: When relevant and material matter offered in evidence by any party is embraced in a book, paper, or document containing other matter not material or relevant, the party offering the same must plainly designate the matter so offered. Only a true copy of such portion of the book, paper or document containing the relevant or material matter in proper form shall be received as an exhibit and in a formal hearing, only after proper authentication. Like copies of such matter shall be delivered by the party offering the same to all other parties or their attorneys appearing at the hearings, who shall be afforded an opportunity to examine the book, paper or document, and to offer in evidence in like manner other portions thereof if found to be material and relevant.

(3) Official records: An official rule, report, order, record or other document, prepared and issued by any governmental authority, when admissible for any purpose may be evidenced by an official publication thereof; or by a copy attested by the officer having the legal custody thereof, or his/her deputy, and accompanied by a certificate that such officer has the custody, made by any public officer having a seal of office, and having official duties in the district or political subdivision in which the record is kept, authenticated by the seal of his/her office.

(4) Commission's files: Paper and documents on file with the Commission, if otherwise admissible, and whether or not the Commission has authority to take official notice of the same under WAC 261-40-220(2), may be introduced by reference to number, date, or by any other method of identification satisfactory to the presiding officer. If only a portion of any such paper or document is offered in evidence, the part so offered shall be clearly designated. Intra-office Commission memoranda and reports when designated as confidential by the Commission to the extent permitted by RCW 42.17.310, are not public records subject to inspection; nor shall such documents be introduced in evidence.

(5) Records in other proceedings: In case any portion of the record in any other proceeding is admissible for any purpose and is offered in evidence, a true copy of such portion shall be presented for the record in the form of an exhibit unless:

(a) The person offering the same agrees to supply such copies later at his/her own expense, if and when required by the Commission; and

(b) The portion is specified with particularity in such manner as to be readily identified; and

(c) The parties represented at the hearing stipulate upon the record that such portion may be incorporated by reference,

and that any portion offered by any other party may be incorporated by like reference; and

(d) The presiding officer directs such incorporation.

(6) Copies of exhibits to opposing counsel: When specially prepared exhibits of a documentary character are offered in evidence, unless the presiding officer otherwise directs, copies must be furnished to opposing counsel, (if any), all Commission members, staff, and in a formal hearing, the presiding officer. Whenever practicable, the parties should interchange copies of exhibits before, at at the commencement of the hearing.

WAC 261-40-230 STIPULATION AS TO FACTS. The parties to any Commission proceeding or investigation may enter into a written stipulation as to the facts or any portion thereof involved in such proceeding or investigation. Such stipulation may be included as part of the staff statement of findings and recommendations or hospital's response or may be a separate submittal to the Commission. It shall be binding upon the parties thereto and not only may be regarded and used by the Commission or presiding officer as evidence at a hearing, but also may be one of the bases for the Commission's findings and its recommendation regarding a hospital's annual budget submittal. It is desirable that the facts be thus agreed upon whenever practicable. Nevertheless, proof by evidence of the facts stipulated to, may still be required notwithstanding the stipulation of the parties.

PART III
SPECIAL INFORMAL HEARING PROCEDURES

WAC 261-40-300 APPEARANCES AND ATTENDANCE AT INFORMAL HEARING. The presiding officer conducting an informal hearing may require representatives of the hospital, staff members responsible for the statement of findings and recommendation, and members of the general public who have submitted written testimony regarding such hospital's annual budget submittal, that are in attendance, to orally identify themselves, their address, and their interest in the matter to be considered by the Commission so that the identity and interest of such persons will be known to those at the hearing. Representatives of the hospital are not required to attend the informal hearing conducted by the Commission regarding that hospital's annual budget submittal; such failure to attend, however, may result in Commission member's questions remaining unanswered, which, itself, may lead to the modification or disapproval of rates, rate schedules, other charges, or changes therein proposed in such submittal.

WAC 261-40-305 RECORD OF INFORMAL HEARING. No verbatim record shall be kept of Commission informal hearing proceedings; the Commission's secretary, however, shall record a summary of the testimony presented to the Commission as well as all questions

asked by Commission members and the responses given thereto. Such summary, together with the hospital's annual budget submittal and response (if any), the staff statement of findings and recommendations, and written testimony submitted by the general public shall constitute the record of the Commission's informal hearing process.

WAC 261-40-310 QUESTIONS BY COMMISSION MEMBERS. At any point during an informal hearing, questions may be asked by Commission members of any representative(s) of the hospital the annual budget submittal of which is being reviewed by the Commission, members of the staff, and members of the general public who have submitted to the Commission written testimony regarding the matter subject to Commission review and action.

WAC 261-40-315 COMMISSION RIGHT TO TERMINATE INFORMAL HEARING. The Commission may terminate an informal hearing at any time either to protect substantial rights of the public, a hospital, or the Commission or its staff; or, in connection with an annual budget submittal before it for review, to assure all purchasers of that hospital's health care services that total hospital costs are reasonably related to total services, that hospital rates are reasonably related to aggregate costs, and that rates are set equitably among all purchasers of these services without undue discrimination. Whenever an informal hearing is so terminated, the Commission shall attempt to give advance notice of such action to the hospital, staff, and public, but it is not required to do so. In the event an informal hearing is so terminated, the Commission shall immediately schedule a formal hearing regarding the annual budget submittal previously being reviewed in the informal hearing.

PART IV
FORMAL HEARING PROCEDURES

WAC 261-40-400 OPPORTUNITIES FOR FORMAL HEARINGS. (1) Petition for reconsideration of informal hearing decision: A hospital or other person that has been adversely affected by a final decision of the Commission in an informal hearing, may petition the Commission for a reconsideration of its decision through a formal hearing process. Such petition shall state in detail the issues or portions of the Commission's informal hearing decision that should be reconsidered by the Commission, together with the reasons therefor.

(2) As initial hearing on hospital's annual budget submittal: A hospital may submit its annual budget submittal to the Commission, together with a petition that it be considered initially in a formal hearing rather than informal hearing pursuant to Part III of this chapter, only with respect to the second and subsequent annual budget submittals subject to review and approval by the Commission.

WAC 261-40-405 COMMISSION ACTION ON PETITION FOR FORMAL HEARING. (1) General: At its earliest opportunity the Commission shall consider and approve or deny a petition submitted pursuant to WAC 261-40-400(1), and shall approve a petition submitted pursuant to WAC 261-40-400(2).

(2) Criteria for denial of WAC 261-40-400(1) petition: A petition submitted to the Commission pursuant to WAC 261-40-400(1) may be denied on the following grounds:

(a) The petition is frivolous;

(b) The petitioner has not been adversely affected by the Commission's informal hearing decision or has been adversely affected to such a minor amount that reconsideration is not justifiable;

(c) The reasons for reconsideration stated in the petition do not justify reconsideration.

(3) Notice of Commission action: The petitioner shall be notified in writing of the Commission's action regarding the petition, together with the reasons therefor, following such action.

(4) Effect of Commission action: (a) No stay of enforcement or effect of the informal hearing decision: Neither the filing with the Commission pursuant to WAC 261-40-400(1) nor the granting of a petition for reconsideration through the formal hearing process of all or any portions of a decision by the Commission made in an informal hearing, shall stay enforcement or the effect of the Commission's decision in the informal hearing.

(b) De novo hearing on reconsideration: Issues included in the petition for formal hearing reconsideration shall be considered on a de novo basis by the Commission.

(c) Reviewability of action: A decision by the Commission denying a petition for reconsideration submitted pursuant to WAC 261-40-400(1) shall be subject to judicial review in accordance with Ch. 34.04 RCW.

WAC 261-40-410 HEARING EXAMINER. The Commission, upon motion, may designate one of its members, or appoint a nonmember, as a hearing examiner, who shall act on behalf of the Commission and serve as the presiding officer in any formal hearing before the Commission until such time as he/she has filed with the Commission and served on all parties a copy of his/her proposed order.

The hearing examiner shall have all the procedural rights and duties of the Commission when presiding in a formal hearing.

WAC 261-40-415 CLASSIFICATION OF PARTIES. Parties to proceedings before the Commission shall be styled applicants, intervenors, petitioners, or protestants, according to the nature of the proceeding and the relationship of the parties thereto.

(1) Applicants: Hospitals applying for any right or authority from the Commission, including an approved rate, rate schedule, or other charges, or any change therein, or the reconsideration of an informal hearing decision shall be styled "applicants".

(2) Intervenors: Persons permitted to intervene, as hereinafter provided, shall be styled "intervenors".

(3) Petitioners: Persons petitioning for opportunity to intervene, or for other relief shall be styled "petitioners".

(4) Protestants: Persons, including the staff, opposing petitions or applications or seeking the disapproval or modification of requests therein shall be styled "protestants".

WAC 261-40-420 INTERVENTION. (1) General intervention: Any person, other than the original parties to the proceeding, who desires to appear and participate in any proceeding before the Commission, and who does not desire to broaden the issues of the original proceeding, may petition in writing for leave to intervene in the proceeding prior to, or at the time, it is called for hearing; or may make an oral motion for leave to intervene at the time of the hearing. No such petition or motion shall be filed or made after the proceeding is underway, except for good cause shown. The petition or motion to intervene must disclose the name and address of the person intervening; the name and address of such person's attorney, if any; such person's interest in the proceeding, and position in regard to the matter before the Commission.

(2) Special intervention: Any person other than the original parties to the proceeding, who shall desire to appear and participate in any proceeding before the Commission, and who desires to broaden the issues of the original proceeding, shall petition in writing for leave to intervene in the proceeding, which petition shall be filed with the Commission and copies thereof shall be mailed to the original parties to the proceeding at least ten days prior to the date of the hearing. The petition must disclose the name and address of the person seeking to intervene, the name and address of such person's attorney, if any; such person's interest in the proceeding, and position in regard to the matter before the Commission; and must include a statement setting forth clearly and concisely the facts supporting the relief sought by the petitioner.

(3) Disposition of petitions and motions to intervene: Petitions and motions to intervene shall be considered first in a formal hearing, or may be set for prior hearing; an opportunity shall be afforded the original parties to be heard thereon. If it appears, after such consideration, that the petition or motion discloses a substantial interest in the subject matter of the hearing, or that participation of the petitioner may be in the public interest, the Commission may grant the same, which may be done by oral order at the time of the hearing. Thereafter such petitioner shall become a party to the proceeding and shall be known as an "intervenor", with the same right to produce witnesses and of cross-examination as other parties to the proceeding. Whenever it appears, during the course of a proceeding, that an intervenor has no substantial interest in the proceeding, and that the public interest will not be served by such intervention therein, the Commission may dismiss such person from the proceeding; PROVIDED, HOWEVER, That a party whose intervention has been allowed shall not be dismissed from a proceeding except upon notice and a reasonable opportunity to be heard.

WAC 261-40-425 RULES OF PRACTICE BEFORE COMMISSION. No person may appear in a representative capacity before the Commission in a formal hearing involving the taking of testimony and formulation of a record subject to review by the courts other than the following:

(1) Attorneys at law duly qualified and entitled to practice before the Supreme Court of the State of Washington;

(2) Certified public accountants qualified and entitled to practice in the State of Washington; and

(3) Upon permission of the presiding officer at such hearing, a bona fide officer, trustee, director, or full time employee of an individual, partnership, corporation, comprehensive health planning agency, or hospital who appears for such planning agency, or hospital.

WAC 261-40-430 PLEADINGS. (1) Pleadings enumerated: Pleadings before the Commission shall be applications, petitions, responses, replies, and motions.

(2) Verification: All pleadings, except the Commission's own motions, shall be verified in the manner prescribed for verification of pleadings in the Superior Court of Washington.

(3) Time for motions: Any motion directed toward an application or petition must be filed before the response is due, otherwise such objection must be raised in the response. If a motion directed toward response, it must be filed before the reply is due, otherwise such objection must be raised in the reply. If a motion is directed toward a reply, it must be filed within ten days after service of the reply.

(4) Time for response or reply: A response, if made, must be filed within ten days, and a reply, if made, must be filed within ten days, after the service of the pleading against which it is directed, unless otherwise provided in these rules or ordered by the Commission. Whenever the Commission believes the public interest requires expedited procedure it may shorten the time required for any response or reply.

(5) Defective pleadings: Upon the filing of any pleading, it will be inspected by the Commission and if found to be defective or insufficient, it may be returned to the party filing it for correction.

(6) Liberal construction: All pleadings shall be liberally construed with a view to effect justice between the parties, and the Commission will, at every stage of a formal hearing, disregard errors or defects in the pleadings or proceeding which do not affect the substantial rights of the parties.

(7) Amendments: The Commission may allow amendments to the pleadings or other relevant documents at any time upon such terms as may be lawful and just, provided that such amendments do not adversely affect the interest of persons who are not parties to the proceeding.

(8) Response: Except as otherwise provided in subsection (4), any party who desires to contest an application or petition or make any representation to the Commission in connection therewith except a general objection to affirmative Commission action with respect to such application or petition (in which case no response shall be required) shall file with the Commission and serve upon the applicant or petitioner a response thereto.

Any response shall be so drawn as to advise the parties and the Commission fully and completely of the party's objection to affirmative Commission action with respect to such application

or petition; it shall admit or deny specifically and in detail all material allegations of the application or petition. In case a party fails to respond within the time specified in subsection (4) such party shall be deemed to have objected generally to affirmative Commission action with respect to the application.

(9) Reply: An applicant or petitioner desiring to reply to a response shall file the same with the Commission, together with proof of service, within the time set forth in subsection (4). Failure to file a reply within said time shall be deemed a general disagreement with the material in the response.

(10) Motions: Subject to the provisions of subsection (6), the practice respecting motions including the grounds therefor, and forms thereof, shall conform insofar as possible with the practice relative thereto in the Superior Court of Washington.

WAC 261-40-435 FORMS. A hospital applying to the Commission for the approval of a rate, rate schedule, other charges, or any change therein as described in its annual budget submittal, shall submit to the Commission such information as the Commission shall require pursuant to Ch. 70.39 RCW and WAC 261-30-040. In addition, such hospital, as well as any other party shall generally adhere to the following form in connection with such action before the Commission:

At the top of the page shall appear the wording "Before the Washington State Hospital Commission". On the left side of the page below the foregoing the following caption shall be set out: "In the Matter of the Application of (name of hospital) for the Approval of Hospital Rates". Opposite the foregoing caption shall appear the type of pleading (e.g., "Application", "Response", etc.).

The body of the pleading shall be set out in numbered paragraphs. The first paragraph shall state the name and address of the party submitting the pleading. The second paragraph shall set out all statutes or rules that may be brought into issue by the pleading. Succeeding paragraphs shall set out the statement of facts relied upon. The concluding paragraphs shall contain the request for action sought by the party.

WAC 261-40-440 SERVICE OF PLEADINGS. (1) Service by parties: Service of pleadings by parties shall be made by delivering six legible copies to the Commission and one copy to every other party, in person or by mail, properly addressed with postage prepaid. Except as otherwise provided, when a party has appeared by attorney or other authorized representative, service upon such attorney or representative will be deemed valid service upon the party of all future pleadings and of all orders of the Commission in such proceeding. Service of pleadings shall be deemed complete when a true copy of such paper or document, properly addressed and stamped, is deposited in the United States Mail. Attorneys or other authorized representatives withdrawing from a proceeding shall immediately so notify the Commission and all parties to the proceeding.

(2) Service by Commission: All notices, responses, findings of fact, opinions, and orders required to be served by the Commission may be served by mail and service thereof shall

be deemed complete when a true copy of such paper or document, properly addressed and stamped, is deposited in the United States mail.

(3) Certificate of service: There shall appear on the original of every pleading when filed with the Commission either an acknowledgement of service, or the following certificate:

"I hereby certify that I have this day served the foregoing document upon all parties of record in this proceeding, by delivering a copy thereof in person to (here name persons served) or by mailing a copy thereof, properly addressed with postage prepaid, to each party to the proceeding or such party's attorney, or authorized representative.

Dated at _____ this _____ day of _____.

(Signature _____

(Of counsel for _____)

WAC 261-40-445 PREHEARING CONFERENCES. (1) General: When issues are joined in any formal hearing, the presiding officer may, by written notice, request all interested parties to attend, with or without counsel, a prehearing conference for the purpose of determining the feasibility of settlement, or of other matters to aid in its disposition. The presiding officer shall preside at such conference to consider:

(a) Simplification of the issues;

(b) The necessity or desirability of amendments to the pleadings;

(c) The possibility of obtaining admissions of fact and of documents which will avoid unnecessary proof;

(d) Limitations on the number and consolidation of the examination of witnesses;

(e) The procedure at the hearing;

(f) The distribution of written testimony and exhibits to the parties prior to the hearing; and

(g) Such other matters as may aid in the disposition of the proceeding, or settlement thereof.

(2) Notice as to simplified issues: Following the prehearing conference a proposed form of notice of the formal hearing, if one is to be had, reciting the action taken at the conference, the amendments allowed to the pleadings, and the agreements made by the parties concerning all of the matters considered shall be submitted by mail as provided by WAC 261-40-440(2) to the parties or their attorneys, or other authorized representatives, for approval. If no objection to such form of notice is filed within five days after the date such notice is mailed, it shall be deemed to be approved. This notice when so approved and after due service, shall limit the issues to be heard at the hearing to those not disposed of by admissions or agreements of the parties or their counsel, and will control the subsequent course of the proceeding.

(3) Recessing hearing for conference: In any proceeding the presiding officer may, in his/her discretion, call the parties together for a conference prior to the taking of testimony, or may recess the hearing for such a conference, with a view to carrying out the purpose of this rule. The presiding officer shall state on the record the results of such conference.

WAC 261-40-450 HEARINGS. The time and place of holding formal hearings will be set by the presiding officer and notice thereof served upon all parties at least twenty days in advance of the hearing date, unless the presiding officer finds than an emergency exists requiring the hearing to be held upon less notice when all parties agree to less notice of such hearing. An effort will be made to set all formal hearings sufficiently in advance so that all parties will have a reasonable time to prepare their cases, and so that continuances will be reduced to a minimum.

WAC 261-40-455 APPEARANCES. Parties shall enter their appearances at the beginning of the hearing by giving their names and addresses in writing to the reporter who will include the name in the minutes of the hearing. Appearance may be made on behalf of any party by an attorney or other authorized representative, and thereupon all future notices, pleadings and orders may be served upon such attorney or representative, and such service shall be considered valid service for all purposes upon the party represented. The presiding officer conducting the hearing may, in addition, require appearances to be stated orally, so that the identity and interest of all parties present will be known to those at the hearing.

WAC 261-40-460 FAILURE OF HOSPITAL TO APPEAR AT FORMAL HEARING. In the event a representative of a hospital fails to appear at the time and place set for the formal hearing of that hospital's annual budget submittal, said hearing may be continued to a later period to be set by the presiding officer to enable said representative to attend; but if at the time set for the resumption of the hearing said hospital is not represented, the hospital's submittal may be disapproved.

WAC 261-40-465 TESTIMONY UNDER OATH. Except matters noticed officially or entered by stipulation, all testimony given during Commission hearings shall be sworn to or affirmed as being the truth in order to be considered by the Commission. Before making any presentation or taking the witness stand each person shall swear (or affirm) that the testimony he/she is about to give in the hearing before the Commission shall be the truth, the whole truth and nothing but the truth.

WAC 261-40-470 RECORD OF PROCEEDINGS. A full and complete record of all proceedings in any formal hearing had before the Commission shall be taken down by a reporter appointed by the Commission. In case of an action to review any order of the Commission, a transcript of such testimony, together with all exhibits introduced, and of the record and proceedings in the cause, shall constitute the record of the Commission.

WAC 261-40-475 DISPOSITION OF MOTIONS: CONSOLIDATION OF PROCEEDINGS. (1) Disposition of motions: The Commission may direct all motions to be submitted for Commission decision on either written or oral argument, and may permit the filing of affidavits in support of contravention thereof. Motions filed by different parties but involving the same point of law may be set for hearing at the same time.

(2) Consolidation of proceedings: Two or more proceedings where the facts or principles of law are related may be consolidated and heard together.

WAC 261-40-480 BRIEFS. Briefs may be filed in any formal Commission hearing by any interested party, and shall be filed by any party to the proceeding upon the request of the presiding officer, and within such time as shall he/she directs. The presiding officer may require the filing of all briefs within three days after the close of the hearing if he/she considers the proceeding to be such that an order should issue promptly; and in the case of matters requiring an immediate decision, he/she may require the parties, or their counsel, to present their arguments and authority orally at the close of the hearing, instead of by written brief. Briefs should set out the leading facts and conclusion which the evidence tends to prove, and point out the particular evidence relied upon to support such conclusion. Briefs may be printed multilithed, mimeographed, typewritten or otherwise mechanically reproduced (size 8 1/2" x 11"), and all copies shall be clearly legible. Six copies of each brief shall be filed with the Commission and copies thereof shall be served on all parties to the case, or their counsel, and proof of such service furnished to the Commission in the manner provided by WAC 261-40-440(3).

WAC 261-40-485 ORDERS. (1) Preparation of proposed order: The presiding officer for a formal hearing shall prepare a proposed order including findings of fact, conclusions of law, and a decision regarding the hospital's annual budget submittal and the rates, rate schedules, other charges, and changes therein; and the same shall be served upon all parties of record.

(2) Exceptions; Number filed and time for filing: Six copies of exceptions to proposed orders must be filed with the Commission and a copy must be served upon all other parties within twenty days from the date of issuance of said order, unless a different time for filing is designated by the Commission at or following the issuance of the proposed order. Proof of service must be made in accordance with WAC 261-40-440(3).

(3) Exceptions: Who may file: Any party of record may file exceptions to the presiding officer's proposed order.

(4) Exceptions: Contents: Exceptions to proposed orders shall be specific and must be stated and numbered separately. Exceptions to findings of fact must be supported by a reference to that page or part of the record or in the alternative by a statement of the evidence relied upon to support the exception, and shall be accompanied by a recommended finding of fact.

Exceptions to conclusions of law must be supported by reference to the appropriate statute or regulation involved and shall be accompanied by a corrected conclusion of law. When exceptions are taken to conclusions in the summary portion of the proposed order there shall be included a statement showing the legal or factual justification for such exceptions, together with a statement showing how the alleged defect in the summary affects the findings of fact or conclusions of law, or the ultimate decision.

(5) Replies: Six copies of a reply to exceptions must be filed with the Commission and a copy served upon the excepting party within ten days of the date of service of the exceptions, unless a different time for filing is designated by the Commission.

(6) Briefs and arguments supporting exceptions or replies: Briefs or written arguments supporting exceptions or replies thereto shall be attached to such documents and shall be served and filed in the same manner as provided in subsections (2) and (5). The Commission may in its discretion hear oral arguments at a time and place to be designated by it upon notice to all affected parties.

(7) Final Order: After reviewing the exceptions, replies, briefs, oral arguments, if any, and the record or such portions thereof as may be cited by the parties, a majority of the Commission may affirm the proposed order by an appropriate final order, or it may make such changes as it deems necessary in its final order. The statutory time for review proceedings shall not commence until the date of the Commission's final order.

WAC 261-40-490 NO DISCUSSION OF PROCEEDING UNTIL DECISION. After the filing of an application or petition in a contested formal proceeding and prior to the issuance of a final order therein, no party to the proceeding or party's counsel, shall discuss the merits of such matter or proceeding with any Commission member or with the presiding officer involved, unless reasonable notice is given to all parties who have appeared therein, to enable such parties to be present during such discussion. When, after filing of an application or petition and prior to the issuance of a final order thereon, letters are directed to the Commission, or any member of its staff, regarding a formal proceeding, copies of such letters shall be mailed to all parties of record and proof of such service furnished to the Commission.

APPENDIX C

Participants and Individual Status: Washington Rate-Setting Program

PARTICIPANTS AND INDIVIDUAL STATUS

Type I

HOSPITAL	LOCATION CITY, COUNTY	FISCAL YEAR BEGINNING	BEDS
Cascade General	Leavenworth, Chelan	Jan. 1	31
Central Washington Health Services	Wenatchee, Chelan	Jan. 1	162
Doctors Hospital	Seattle, King	June 1	177
Island	Anacortes, Skagit	Jan. 1	56
Klickitat Valley	Goldendale, Klickitat	Jan. 1	38
Mark E. Reed Memorial	McCleary, Grays Harbor	Jan. 1	26
Mason General	Shelton, Mason	Jan. 1	66
Memorial	Odessa, Lincoln	Jan. 1	21
Memorial	Pullman, Whitman	May 1	42
Morton General	Morton, Lewis	July 1	26
Newport Community	Newport, Pend Oreille	Jan. 1	23
Northgate General	Seattle, King	June 1	87
Northwest	Seattle, King	Jan. 1	194
Ocean Beach	Ilwaco, Pacific	Jan. 1	25
Olympic Memorial	Port Angeles, Clallam	Jan. 1	86
Othello Community	Othello, Adams	Jan. 1	46
Providence	Everett, Snohomish	Jan. 1	193
St. Frances Xavier Cabrini	Seattle, King	Jan. 1	263
St. Helen	Chehalis, Lewis	July 1*	58
St. Josephs	Aberdeen, Grays Harbor	July 1	109
St. Josephs	Bellingham, Whatcom	July 1	107
St. Mary Community	Walla Walla, Walla Walla	Jan. 1	116
Seattle General	Seattle, King	Oct. 1	133
Spokane Valley General	Spokane, Spokane	Jan. 1	123
Swedish Hospital Medical Center	Seattle, King	Jan. 1	448
University	Seattle, King	July 1	328
Valley General	Monroe, Snohomish	Jan. 1	31
Valley General	Renton, King	Jan. 1	269
Valley Memorial	Sunnyside, Yakima	July 1	38
Virginia Mason	Seattle, King	Jan. 1	292
West Seattle General	Seattle, King	Sept 1	185
Whitman Community	Colfax, Whitman	Jan. 1	58
Yakima Valley	Yakima, Yakima	Nov. 1	226
	TOTAL		4,083

*P.R. payment will begin on the fiscal year beginning after June 30, 1976.

PARTICIPANTS AND INDIVIDUAL STATUS (Continued)

Type II

HOSPITAL	LOCATION CITY, COUNTY	FISCAL YEAR BEGINNING	BEDS
Ballard Community	Seattle, King	Nov. 1	171
Burien General	Seattle, King	Jan. 1	104
Centralia General	Centralia, Lewis	July 1	47
Columbia Basin	Ephrata, Grant	Jan. 1	29
Community Memorial	Enumclaw, King	Apr. 1	38
Deaconess	Spokane, Spokane	Jan. 1	329
Doctor's Hospital of Tacoma	Tacoma, Pierce	July 1	70
Evergreen General	Kirkland, King	Jan. 1	76
General Hospital of Everett	Everett, Snohomish	Jan. 1	222
Grays Harbor Community	Aberdeen, Grays Harbor	Nov. 1	99
Harborview Medical Center	Seattle, King	July 1	300
Holy Family	Spokane, Spokane	Jan. 1	228
Jefferson General	Port Townsend, Jefferson	Jan. 1	42
Kadlec	Richland, Benton	Jan. 1	136
Kennewick General	Kennewick, Benton	Jan. 1	60
Lake Chelan Community	Chelan, Chelan	Jan. 1	28
Lakewood General	Tacoma, Pierce	Jan. 1	114
Mid-Valley	Omak, Okanogan	Jan. 1	38
Mount Linton	Metaline Falls, Pend Oreille	Jan. 1	19
New Valley Osteopathic	Yakima, Yakima	Apr. 1	30
North Valley	Tonasket, Okanogan	Jan. 1	30
Overlake Memorial	Bellevue, King	Oct. 1	177
Quincy Valley	Quincy, Grant	Jan. 1	16
Ritzville Memorial	Ritzville, Adams	Jan. 1	20
Sacred Heart Medical Center	Spokane, Spokane	Jan. 1	556
Saint John's	Longview, Cowlitz	July 1*	235
St. Joseph's	Chewelah, Stevens	Jan. 1	33
St. Luke's Memorial	Spokane, Spokane	Jan. 1	146
Tri-State Memorial	Clarkston, Asotin	Oct. 1	62
United General	Sedro Woolley, Skagit	Jan. 1	80
Waldo General	Seattle, King	Jan. 1	80
Walla Walla General	Walla Walla, Walla Walla	Jan. 1	71
Whidbey General	Coupeville, Island	Jan. 1	44
	TOTAL		3,730

*P.R. payment will begin on the fiscal year beinning after June 30, 1976.

PARTICIPANTS AND INDIVIDUAL STATUS (Continued)

Type III

HOSPITAL	LOCATION CITY, COUNTY	FISCAL YEAR BEGINNING	BEDS
Allenmore	Tacoma, Pierce	Jan. 1	155
Auburn General	Auburn, King	July 1	90
Cascade Valley	Arlington, Snohomish	Jan. 1	36
Central Memorial	Toppenish, Yakima	July 1	63
Childrens Orthopedic & Medical Center	Seattle, King	Oct. 1	195
Cowlitz General	Longview, Cowlitz	Jan. 1	87
Dayton General	Dayton, Columbia	Jan. 1	28
Garfield County Memorial	Pomeroy, Garfield	Jan. 1	54
Good Samaritan	Puyallup, Pierce	Oct. 1	201
Harrison Memorial	Bremerton, Kitsap	May 1	210
Kittitas Valley Community	Ellensburg, Kittitas	Jan. 1	50
Lincoln	Davenport, Lincoln	Jan. 1	24
Mary Bridge Children's	Tacoma, Pierce	Oct. 1	68
McKay Memorial	Soap Lake, Grant	Jan. 1	14
Mount Carmel	Colville, Stevens	Jan. 1	55
Okanogan-Douglas County	Brewster, Okanogan	July 1	50
Our Lady of Lourdes	Pasco, Franklin	July 1	80
Prosser Memorial	Prosser, Benton	Jan. 1	45
Providence Medical Center	Seattle, King	Jan. 1	433
Riverton General	Seattle, King	July 1	109
St. Elizabeth	Yakima, Yakima	Jan. 1	239
St. Joseph Hospital & Health Care Center	Tacoma, Pierce	July 1	260
St. Luke's General	Bellingham, Whatcom	Jan. 1	112
St. Peter	Olympia, Thurston	Jan. 1	180
Samaritan	Moses Lake, Grant	Jan. 1	50
Skagit Valley	Mt. Vernon, Skagit	Jan. 1	156
Skyline	White Salmon, Klickitat	Jan.1	40
Standring Memorial Osteophathic	Seattle, King	July 1	53
Stevens Memorial	Edmonds, Snohomish	Jan. 1	159
Sunnyside General	Sunnyside, Yakima	July 1	38
Tacoma General	Tacoma, Pierce	Jan. 1	299
Willapa Harbor	South Bend, Pacific	Jan. 1	39
	TOTAL		3,672

APPENDIX D

APPENDIX D

PERSONS WHO PROVIDED INFORMATION USED IN THIS CASE STUDY

Mr. Frank Baker
Director
Washington State Hospital Commission

Mr. John Bigelow
President
Washington State Hospital Association

Mr. Jon Bowman
Commissioner
Washington State Hospital Commission

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Department of Social and Health Services

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Mr. Gordon Davidson
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President
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Mr. Paul Gronnert
Senate Committee on Social and Health Services
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Mr. Doug Hoffman
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Sister Charlotte Van Dyke
Commissioner
Washington State Hospital Commission

Mr. Kenneth Webster
Commissioner
Washington State Hospital Commission

Mr. John Welch
House Committee on Social and Health Services
Olympia, Washington

Health Care Financing Grants and Contracts Reports

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